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INTRODUCTION

ADMINISTRATIVE COMPONENTS

SYSTEM OPERATION COMPONENTS

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(continued)

A. Summary of proposed changes within this Regional Plan, which require specific Department approval: *(one page maximum)* Specify all required changes contained within this Plan in the following areas: (1) recommended numbers of Department-approved verified prehospital services within the region; (2) recommended numbers and/or levels of Department-designed trauma services and/or rehabilitation services within the region; (3) current Department-approved regional Patient Care Procedures and/or County Operating Procedures; (4) request(s) for Department approval of regional council-adopted higher-than-state minimum standard(s), for implementation within the region.

1. North Central Region recommended numbers of DOH approved verified prehospital services within the region Table B. (min/max)

   With input and recommendations of the respective Local Councils, the following recommendations have been accepted by the Regional Council and are recommended to the DOH for this Regional Plan.

   Grant County Local Council recommended and the Regional Council recommends increasing the maximum number of verified EMS agencies as follows;
   ALS verified transport agencies within the County from 2 to 6
   ILS verified transport agencies within the County from 2 to 5
   BLS verified transport agencies within the County from 6 to 8
   BLS verified aid agencies within the county from 6 to 9

   Okanogan/North Douglas County Local Council recommended and the Regional Council recommends increasing the maximum number of verified EMS agencies as follows;

   BLS verified aid agencies within the county from 7 to 9

2. The North Central Region recommends that the numbers and/or levels of Department of Health-designated trauma services be increased in the following areas:
   a. Level IV – increased to five (5) to reflect the current number of facilities at that level.
   b. Level V – increased to four (4) to reflect the current number of facilities at that level.

3. North Central Region Revised Patient Care Procedures
   a. The first four (4) of the Patient Care Procedures attached as Appendix #1 have been revised and recommended by the Regional Council.
      1. Dispatch of Agencies
      2. Response Times
      3. Timely & Appropriate EMS Response
      4. Helicopter Response

4. Grant County's County Operating Procedures
   a. Two County Operating Procedures attached as Appendix #2 have been reviewed and recommended by the Regional Council.
      1. Tiered Response and Rendezvous

B. Executive Summary *(two pages maximum)*

This plan represents the efforts of the North Central Regional EMS & Trauma Care Council, its committees, sub-committees and Local Councils, agencies, providers and staff to enhance the quality of care within the region to all patients, under the authority of the Department of Health, to design a model trauma care system for the four counties, comprising the north central region of the State of Washington.

The North Central Regional EMS & Trauma Care Plan for 2000 – 01 sought to further develop and implement an efficient and effective trauma system, incorporated into the existing EMS prehospital system and healthcare facility network, designed to prevent trauma injuries, effectively treat and rehabilitate trauma patients. The previous plan reflected more if a change in leadership and accountability within the region while this plan represents a movement within the region to enhance and improve patient care to all patients in our four county region. The region has made great strides in the implementation of new committees, reviewing and recommending PCPs, COPs, reviewing and defining response areas and furthering the advancement of patient care in the region.

We have accomplished the following;

- Re-establishing vital committees
- Developing fellowship between the agencies in the region
- Developing relationships and partnerships between hospital, pre-hospital and clinical disciplines
- Developing and maintaining a stable leadership within the council
- Supporting the Local Councils with all tasks assigned to them
- Providing consistent direction to all committees, sub-committees, council members, local councils

Our region addressed many challenging activities and issues over the past two years. These challenges were part of the improved delivery of EMS care within the region.

- Inter-agency cooperation
- Inter-regional mutual aid and assistance
- Continuing to identify and define response areas
- Improved dispatch to EMS agencies through training and support
- Established partnerships between the regional office and agencies/providers in the region.

The last plan established several general long-term goals, some of which were accomplished and some which are ongoing.

	LONG TERM GOALS	Completed	Ongoing
1.	Raise awareness through the use of effective and specifically targeted injury Prevention and public education programs. Goal = Decreasing the incidence of preventable trauma.		√
2.	Encourage the compliance of all agencies in the submission of data to the state for compilation and dissemination. Goal = Collect data for future decision-making.		√
3.	Promote, assist, and help to assure efficient management of mass casualty incidents whether man-made or natural disaster. Goal = Promote MCI planning and training.		√
4.	Provide EMS training at all levels in the region to ensure quality care while maintaining certification and licensure. Goal = Quality patient care and provider retention.		√
5.	Identify weaknesses in and develop a communications system within the region that is accessible to all providers. Goal = Improve communications in the region.		√
6.	Identify a process for continued scrutiny of existing pre-hospital services, min/max numbers, trauma care and rehabilitation facilities. Goal = Monitor regional capabilities.		√
7.	Encourage cooperation and collaboration between all pre-hospital agencies and trauma care facilities. Goal = Develop and enhance working relationships in the region.		√
8.	Review, develop and update Regional Patient Care Procedures and County Operating Procedures. Goal = Maintain a progressive attitude in developing the region.		√
9.	Further develop quality improvement strategies that will identify system deficiencies and implement improvements. Goal = Continuing participation and follow-up of QI/QA for system development.		√

	NEW GOALS
1.	Sponsor EMD/CBT instructor and dispatcher training to improve quality of service to the communities and prehospital providers. Goal = Improve dispatch services in the region.
2.	Further develop process for review of license and verification applications. Goal = Establish new procedure for applications review for plan compliance and feasibility.
3.	Further develop process for review and evaluation of prehospital and facility min/max numbers. Goal = Establish new process for review of min/max numbers.
4.	Map and identify BLS, ILS and ALS aid agencies and transport agency areas within the region Goal = Complete mapping, description and identification of all response areas within the four county region.
5.	Review and evaluate process for identifying training needs in the region. Goal = Establish new process for the evaluation of training needs for the development of a training plan for the region that includes all levels of prehospital and hospital providers.

I. REGIONAL COUNCIL

A. Leadership: Describe ***only if there are changes*** in the Regional Council's roles and responsibilities, including a "graphic representation" (organizational chart) of the relationship and interrelationships between the Regional Council as lead agency and other organizations within the region which are involved in providing information and/or services relating to the successful implementation and operation of the regional EMS and trauma care system. Include involvement with professional and consumer groups, relationships with local, state, and federal government agencies, and involvement with other non-profit and private sector groups and organizations within the region.

North Central Regional EMS & Trauma Care Council Mission Statement:

"Ensure the highest quality patient care possible through regional policy direction, injury prevention education, resource assistance and educational support, while furthering the goals of the Washington State DOH Office of Emergency Medical Services and Trauma Prevention."

The Regional Council membership, which makes up the board of directors for the non-profit corporation, is comprised of 24 members from the following categories:

Prehospital –8,	Hospital – 4,	Local Elected Officials – 2
MPDs - 3	Consumers – 2,	Law Enforcement – 2,
Local Government Agencies – 3.		

The current organizational structure of the Regional Council is shown in Appendix # 4. There are two committees that are mandated in the bylaws of the Regional Council. They are the Executive and Finance Committee. The Regional Council has opted to combine these two committees into one, the Executive Committee, which holds the responsibilities of both. Their primary responsibility is the management of the business operations and the fulfillment of the contractual obligations.

As has been its history, the North Central Regional EMS and Trauma Care Council meets every other month on the first Wednesday of the month.

The current officers of the council are;

Craig Hutson, President	Cindy Button, Vice-president
Tanya Vallance, Secretary	Tom Keene, Treasurer.

The region has been very diligent in the further development of relationships with other groups that share a similar vision. These groups include;

National Highway Traffic Safety Commission Injury prevention activities	U.S. Dept of Transportation Injury prevention activities
Washington State Traffic Safety Commission Injury prevention activities	American Trauma Society Injury prevention activities
Wenatchee Valley College EMT training	Inland Empire EMS Training Council EMS training
Chelan County Sheriff Emergency management	Wenatchee Police Department Emergency management

Douglas County Sheriff
Emergency management
Multi Agency Comm. of Grant County
Dispatch improvement
Wenatchee Fire and Rescue
Emergency management/IPPE
East Wenatchee Police Dept
Emergency management/IPPE
North Central Washington ESD #171
Injury prevention activities
Quincy Valley Hospital
Injury prevention activities
Ballard Ambulance Service
IPPE/Other activities
Lifeline Ambulance, Inc.
IPPE/Other activities
Aero Methow Rescue Service
IPPE/Other activities
KPQ Radio Station
Public relations

Grant County Sheriff
Emergency management
Okanogan County Sheriff
Emergency management
Mid Valley Hospital
Injury prevention activities
Central Washington Hospital
IPPE/QI/Other activities
Samaritan HealthCare Services
Injury prevention activities
Lake Chelan Valley Ambulance
IPPE/Other activities
Wenatchee World Newspaper
Public relations
Ephrata Ambulance Service
IPPE/Other activities
Wenatchee Valley Senior Center
Injury prevention activities
KW3 Radio Station
Public relations

The above represent only a portion of agencies and others with whom the North Central Regional Council works.

The most improved relationships are the ones that have developed with the three local councils of the North Central Region; Grant County EMS & Trauma Care Council, Greater Wenatchee EMS & Trauma Care Council and Okanogan/N. Douglas Counties EMS & Trauma Care Council. These three local councils have made major steps in providing direction to the EMS agencies within the respective areas. As we move forward into the next biennium, their participation will grow and their input will become even more valuable.

B. **Council Operations:** If there are any difficulties with the current internal operations of the Regional Council, describe what changes will be made and discuss how those operations relate to the statutory responsibilities of the Council. Discuss the board (regional council) and committee structure, and how these relate to internal operations in regard to fulfilling the Regional Council's contractual obligations.

Two areas that exhibit difficulties that will be addressed are; committee operations and regional council representation.

It should be noted that it was a goal of the previous regional plan to form these committees and to have them begin meaningful operation. They have been active in the further development of regional operations.

Patient Care Procedures
Injury Prevention & Public Education
Acute Care Facilities
Training & Education
Communications

It is now our objective to further define the responsibilities of each committee by way of charters, which are Appendix # 3. These charters will reflect the desires of the Department of Health and the North Central Regional EMS & Trauma Care Council and explain each committee's responsibilities in helping the region meet its deliverables within the contract with the Department of Health.

Another area that the regional council will emphasize is the addition of council members of disciplines that are currently underrepresented, such as law enforcement, Level 2 trauma facility representation, consumer and others. As the leadership by the regional council continues to have an impact on the region, more and more items of interest and importance come to the forefront. With this phenomenon comes increased willingness and interest in participating in the process of change as well as the need for varying viewpoints. Recognizing this, we intend to review and possibly change the structure of our council to include these varying perspectives, which will then provide direction in fulfilling our contractual obligations.

II. SYSTEM DEVELOPMENT

A. EMS/Trauma System Plan Development, Maintenance and Evaluation:

The Regional Council conducts needs assessment in three ways;

a. The Communications Committee distributes a needs, strengths and weaknesses survey to all agencies.
b. The Regional Office distributes various surveys, to include needs, strengths, weaknesses and goals. (See Attachment #2)
c. The Regional Council Staff attends all local council meetings to relay information between the Regional Council and the Local Councils.

The development of the regional plan is primarily coordinated by the Regional Council Staff via Regional Plan Assignments. The completion of the plan is dependent upon the Committee Chair Persons and Local Council Chairs diligence to complete the assignments and to forward them to the Regional Council Office for formatting, editing and inclusion into the regional plan. During the development phase, each agency is requested to complete a questionnaire that is fashioned to illicit responses that can be included in the plan document. Agencies that respond by a stated deadline then will be eligible to receive funds from the Regional Council in the form of either needs or discretionary grants.

The implementation of the plan is multi-phasic. Initially, the Regional Council prioritizes the goals and objectives of the plan. That list will then be forwarded to the Local Council for their input and suggestions. The finalized list will then be sent to all agencies within the region for their needs, which are related to each priority. The results of which will then be addressed by the Regional Council for opportunities to impact the EMS agencies.

The Regional Council Executive Committee will conduct the review and evaluation of the effectiveness and accomplishments. They will then report the results to the Regional Council for further direction and guidance. The Executive Committee will then present the plan to the Regional Council for review and eventual approval for recommendation to the Steering Committee and DOH.

B. Local government ordinances:

The Regional Council is aware of ordinances, resolutions and inter-local agreements within the region that impact EMS services. The City of Moses Lake has passed an ordinance establishing their EMS service. Grant County Fire Districts #5, 12, 15 are working jointly on resolutions for further development of ALS services within their respective geo-political response areas.

C. Local System Development Costs:

Two areas that will need attention to further develop the efficiency of the local EMS/TC system in the North Central Region are communication and recruitment and retention on volunteers. Funding of purchases of AEDs is also an area where licensed EMS agencies will need assistance. Due to the limited budgets of many agencies, replacement of equipment, specialized and initial training costs are always a concern. The Regional Council encourages all agencies to seek the DOH "Needs Grants" to assist in the purchase of necessary and/or required equipment and training.

a. Communications – There are numerous areas within the North Central Region that have limited or no communications primarily due to terrain. Of these areas, three can be affected by further communication system development. In the Winthrop area, a satellite telephone system seems to be the only avenue available in the Washington Pass area. The estimated cost of such a system is $50,000. The Okanogan/N. Douglas County Local Council will be seeking grant funding to provide the funds to develop this system.
b. Within Grant County, there is a need for an additional radio repeater system that can provide more adequate communication coverage between responders in an area in the northern portion of the county. The estimated cost of the project is $15,000. The Regional Council will be investigating sources for funding during this biennium.
c. In the northern portion of Okanogan County, there has been identified an area where either an additional repeater is needed or one needs to be repositioned. This change will provide for more reliable paging of the volunteer responders in that area. The estimated cost of this project is between $5000 and $15,000. A survey must be completed before a true assessment can be made and a plan for addressing this issue is made.
d. In the area of recruitment and retention of volunteer providers, this problem is systemic not only in the North Central Region, but throughout the State of Washington and the USA. At this time, the North Central Region has not developed an approach that is believed to be effective or promising. Through the cooperation of the Department of Health and other resources, the North Central Region hopes to address this issue and assist the EMS providers in the North Central Region continue to provide the excellent care the citizens of the North Central Region have come to expect. The costs associated with this endeavor are not known as no clear direction has been found.

e. A new ALS transport agency is recommended for operation within Grant County FD #5. There is no direct cost associated with this addition, as it is a privately owned and funded service.
f. With the requirement that by January 1, 2002, all licensed vehicles carry defibrillation capability appropriate to the level of personnel; the Regional Council acknowledges that this may be a financial burden for some agencies. The Regional Council will attempt to assist these agencies with funding whenever possible.

The development and implementation of the following programs is to reduce the incident of serious injury and or death to the public and residents of the North Central Region.

Tread to Safety

Current Status

The Tread to Safety program was developed to address the incidence of falls and hospitalization of senior citizens in the North Central Region. The program was designed to present a fall prevention program to the elderly and provide them with safety information to prevent and influence change in their environment. Included in this presentation is an overview of the possible issues related to injuries and hospitalization in the North Central Region. State and local data is used to support this problem. An updated overhead transparency program was developed this past year to add a more interesting approach to the program presentation. Visual aids are also used to demonstrate the proper type of foot ware, support devices, and the use of cordless phones.

At the end of the program the audience is given a set of bath and shower anti skid treads that can be installed in their bathroom. They also receive a home safety check off sheet. This sheet lists various hazards around the home that can be identified and a check in the proper box will enable the senior citizen or a relative to fix or adjust the problem. A measurable objective for this program for the next biennium would be to contact five hundred senior citizens with a message on falls and injuries. This information was included in a training manual that was presented at our North Central Region conference to prevention specialists from around the area. Refer data tables included with this plan.

Strengths

Senior citizens are very interested in maintaining their health and independence. This program assists them so they don't lose that status. For this reason they listen to the material presented and are interested in improving the area in which they live. This program also benefits the community and health care providers by reducing the incidence of elderly trauma.

Weaknesses

This program is well formatted and addresses the need for environmental change among seniors but changing their long-standing behavior and attitude about safety in and around the home is difficult. There is a need for a follow-up program to reinforce safety practices and encourage senior citizens to continue to develop good safety techniques. A separate program presentation designed for the relatives and caregivers of senior citizens will assist in creating a safe environment for them.

Eastmont High School

Think First

Current Status

The Think First program was designed to address the issue of head and spinal cord injuries among young people. "Use your mind to protect your body" is the message that Rod Bault uses to convince kids to change their attitude about using drugs and alcohol. Rod is a quadriplegic due to a high-speed motorcycle crash. He is paralyzed from the chest down. Rod shares his story and holds back nothing about his regret that he used poor judgment in using drugs and alcohol and driving his motorcycle at a high rate of speed. He explains to the kids what its like to be paralyzed and how it has changed his life forever. It is an emotional presentation and the kids listen intently and seem to get a real feel for Rod and the mistake he made. These presentations are made to individual classes as well as in assembly settings. This is the only program in the North Central Regions prevention presentations that requires financial support from the schools or the region. A specific measurable objective for this program for this biennium would be to contact twenty three hundred students with a message on head and spinal cord injuries. A description of this program and the procedure required to request a presentation was also included in the Injury Prevention Pre-Conference training manual. Data tables are included with this plan.

Strengths

This is a very positive program. The evaluations obtained from the kids after the presentation indicate that Rod had made an impression on them and had influenced them to change their behavior when it comes to the use of alcohol and or drugs.

Weaknesses

The cost of this presentation has always been a concern for the schools requesting the program. For the past few years the Washington Educational Association has subsidized this program to support the smaller schools in the North Central Region. If these funds continue to be offered the Think First program will continue to be a vital part of the prevention program in the region. The lack of presenters for the program has been somewhat of a weakness in the past but long range planning elevates this problem.

Bicycle Safety

Mini Bicycle Rodeo Kit

Current Status

The bicycle safety program in the North Central Region has been and will continue to be very active. The communities throughout the region have a great concern for the safety of their children. For this reason they continue to organize bicycle safety programs and encourage helmet use. These include school safety programs, bicycle helmet distribution, and bicycle rodeos. The Washington Traffic Safety Commission is one of our strongest supporters of bicycle safety. They provide mini grants that afford the opportunity for these communities to purchase bicycle helmets and other safety equipment to support their programs. Local EMS agencies also play an active role in prevention by including bicycle safety as part of their goal to prevent serious injury and or death to the children in the region. A specfic measurable objective for these programs would be to contact eight thousand kids this next biennium with a message on bicycle safety. The communities in the region are very supportive of bicycle safety and continue to develop safety programs every year. Data tables are included with this plan.

Strengths

These bicycle safety programs bring a strong awareness to safety issues among bicycle riders through out the region. Teaching children safety techniques and understanding the laws a bicyclist has to know will enable them to operate their bicycle safely. Bicycle rodeos teach children about proper care of equipment, wearing helmets, and their ability to ride safely. These programs also teach children to help their younger siblings to ride safely.

Weaknesses

Bicycle safety programs are only as good as the people that present the programs and many communities fail to address the issue of bicycle safety in their area.

Trauma Nurses Talk Tough

SR97A North of Wenatchee

Current Status

This program was developed in the Portland area out of Emanuel Hospital. Joanne Fairchild, a trauma nurse for Emanuel Hospital, was very concerned about the increasing number of trauma cases coming into the emergency room and decided to develop a program to address this problem. The program she developed is a slide presentation that can be easily adapted to fit the needs of each individual audience. The items addressed are:

Driving safety:

1. Driver & passenger roles
2. Restraint use and child occupant protection
3. Youth driving issues
4. Impaired driving
5. Underage drinking
6. Bike and pedestrian safety
7. Helmet use
8. Recreational safety including water sports
9. Firearm injuries

There are 3 videos on elementary safety belt use, 313 slides with scripts for 4 different school aged groups and suggestions for adapting the program. A resource list, Program evaluation tools, Divisional Safety Belt Class instruction, “High Risk Drivers” Course Instruction, “Minor in Possession” Class Instructions, Ideas for teaching family safety, and Bicycle safety issues. The slides are very graphic and are all scripted to fit the audience.
The North Central Region and Central Washington Hospital purchased the Trauma Nurses Talk Tough in 1998. The cost was $500.00. Since that time the program has been presented in many schools through out the region. A specific measurable objective for this next biennium would be to contact twelve hundred and fifty kids with a message on the effects of alcohol and driving a motor vehicle. It has also become part of the Sober Roadways program demonstrating the effect alcohol has on the body and driving. Emergency nurses support this program and are a great mechanism for instruction. A data table is included with this plan.

Strengths

This program is well received by students that attended the presentations. The graphic slide presentation carries a strong message about the effect alcohol has on the body the ability to drive a car. The program generates many questions about alcohol and its use by underage people.

Weaknesses

The obvious weakness is the inability for the program to be presented to all students in the region. To answer this problem the region submitted a request for funds to purchase four more sets of the latest edition of this program. The goal is to have this program strategically placed through out the region and accessible to the trauma nurses in the area. This will enable those nurses to reach a much broader audience through the school system.

Drowning Prevention

Current Status

The drowning prevention program is a seasonal program that is ongoing in the region. Due to the vast area of lakes and streams, the region addresses water safety throughout the summer months and into the fall. Employees of swimming pools in the area also emphasize water safety through special water safety classes. During the tourist season water safety is addressed through signage at boat ramps stressing the use of floatation devices. A specific measurable objective for this biennium would be to contact five hundred people with a message on drowning prevention. Local and county agencies support this program through a combined effort of resources and volunteers that develop new and continuing programs. A data table is included with this plan.

Strengths

The communities along with local law enforcement stress the importance of water safety through the use of enforcement boat patrols on major bodies of water. These include the Columbia River and Lake Chelan.

Weaknesses

This is a strong program that has support of many people interested in water safety prevention. The weakness would be the lack of volunteers needed to evaluate the program through observational studies.

Sober Roadways

Current Status

The Sober Roadways program is designed for driver's education classes. This informational class is presented to schools throughout the region on a first come bases.
The presentation addresses all aspects of driving but the main focus is on the impaired driver. The program consists of a slide presentation that has been updated from its original format to include the profiling of local crashes that involve the use of alcohol and or drugs. Blood alcohol informational sheets are also used as a tool for the students to discuss alcohol consumption limits. Laws pertaining to the use of alcohol by minors are also discussed during this presentation. The Trauma Nurses Talk Tough program has been included is this presentation showing the effects alcohol has on the body. A specific measurable objective would be to contact sixteen hundred kids with a message on drinking and driving. Mock car crashes are also part of this program. Support from the school system through the administration body keeps this program before the students on a regular basis. A data table is included with this plan.

Strengths

This is a very positive program that has current updated information contained in the presentation. Students have the opportunity to ask questions about alcohol and other drugs as it relates to the body and driving.

Weaknesses

This program is presented to individual drivers education classes, which for the most part contain 20 to 30 students. The main weakness of this program would be the lack of students contacted through program presentations. More "train the trainer" instructional presentations are needed, in the region, to teach people from the EMS agencies to present this program.

SR97A

Goals of the region

The goals of the IPPE program in the North Central Region are to promote prevention programs through education and program development. Each prevention program has its specific characteristics that include; demographics, time of year and economic indicators. The obvious goal would be to eliminate any serious injury or death to the total population of the North Central Region. This would be a long-range goal. Short-term goals would be to develop educational prevention programs with supporting current data that can be presented through out the region in the school system. The main focus would be to reduce the incident of serious injury and or death.

To accomplish this long term goal will require the cooperation and support of all those agencies in the EMS field. Legislative budget cuts sometimes disturb the progression of these long-range safety programs and their effectiveness. This is an ongoing problem and should be considered when organizing and developing these programs. Evaluation of these programs will be through an evaluation tool developed specifically for each individual program. This tool will be used in the development of future safety programs.

Objectives:

1) Training of agency personnel to present and develop effective prevention programs that would be presented in their respective schools and communities alike.
2) Obtain funding through grant application from state and federal agencies.
3) Develop an active and supporting prevention committee for the North Central Region.

Strategies

To initiate an effective IPPE program in the region that will require the education and training of EMS professionals from all the agencies in the region. Training of people and keeping the enthusiasm and momentum going will be a long-term strategy.

Projected cost:

The best answer to what the projected cost would be for IPPE prevention programs would be how much is a life worth? We do the very best with the resources we have to develop and implement effective prevention programs but the bottom line is money. The annual funds received from the Department of Health for the prevention programs along with grants obtained from other agencies make up the budget for the region.

Activity Measurements

To address this short-term goal objective will require the training of personnel from the agencies in the region to present prevention programs in their respective areas. A prevention-training manual has been developed and will be available to people interested in prevention presentations. Train the trainer classes will also be part of this objective. Teaching providing agencies how to use the manual and present a professional program will also be part of short-term goal. This will include information on how to develop an evaluation tool to track the effectiveness of the programs presented.

Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificates

Fatal Injuries
- Chelan, Okanogan, Douglas, and Grant Counties---------- 1990-1999
- Washington, State---------- 1990-1999

Nonfatal Injury Hospitalizations
- Chelan, Okanogan, Douglas, and Grant Counties---------- 1990-1999
- Washington State---------- 1990-1999

Fatal Traffic Collisions in Washington State---------- 1998

- 1998 Traffic Deaths in Washington State
- All Traffic Deaths, 1993-98
- All Drinking-driver-involved Traffic Deaths, 1993-98

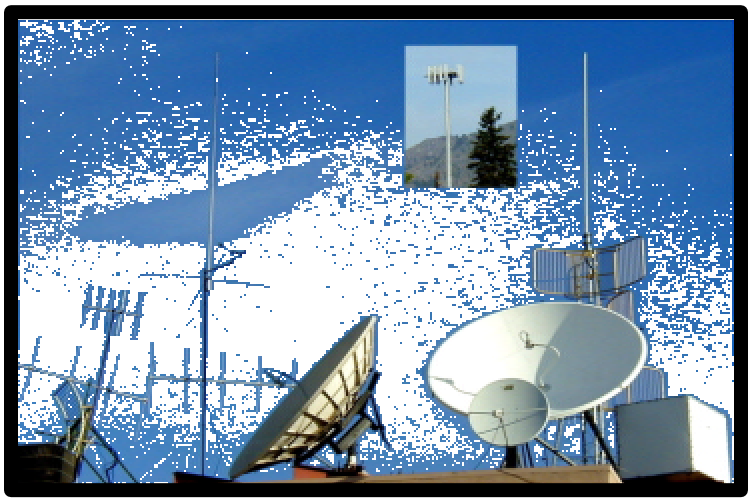
Chelan, Okanogan, Douglas &Grant Counties

Demographics

The North Central Region is the largest region in the state with the least amount of population. The four counties Chelan, Douglas, Okanogan, and Grant have total a population of 208,400 that live in a 12,692 square mile area. There are forty-three EMS agencies in this vast area that respond and provide emergency care to people in need in this area. Of the 797 emergency care professionals 590 are volunteers. They are involved in developing and presenting injury prevention programs. Training providers to present safety programs will be one of the main goals of the region for the next biennium.

The North Central Region also has a vast amount of recreational open water areas including rivers and streams that attract people from all over the state during the summer months. With the volume of people comes the threat of drowning in these waters. During 1995-1999, 34 people, of all ages, lost their life in this four county area due to the lack of and/or improper use of water safety equipment and close supervision of children. Another 22 people were hospitalized during this same period. The North Central Region has addressed this issue by implementing a drowning prevention program focused on educating the public about safety around and in water. This program also includes information on current laws pertaining to the use of personal flotation devises.

The North Central Region is a high tourist area, which is representative of the high fatality rate during the summer months. The four counties have a total driving population of 100,958 that travel in this 12,692 square mile area. This driving population comprises a small percentage of the 4,265,724 statewide but reflects a high use of alcohol among underage drivers. Underage drinking continues to be a concern in the state as it is in the North Central Region. During the period of 1993-1999, according to the Washington Traffic Safety Commissions 1998 Fatal Collision Report, 71% of all underage-drinking fatalities involved the age group of 15-20 year olds. In the period of 1993-1998 in the North Central Region this same age group was responsible for 31 underage fatalities. The overall fatalities for this age group during this five-year period were 655, which included the 57 fatalities that occurred in the Region. These figures demonstrate a need for alcohol education through driver's education classes throughout the Region. Developing educational programs demonstrating the effects alcohol has on the body and driving impairment as a result of underage alcohol use is one of the short and long-term goals of the Region.



IV. PRE-HOSPITAL

A. Communication:

1. Current Status: Describe the current regional communications system, including:

a. Public Access (e.g., E911, etc.)

Public access to EMS services in the North Central Region is good. Currently there are no areas that do not have 911 coverage. In addition, Chelan and Grant Counties have enhanced 911 coverage. As of late, the development of the On-Star system has added another way that the public can access the 911 systems of the region. Due to topographic issues, numerous areas throughout the region have communication gaps. These gaps include radio and cell phone limitations. This presents a possible risk for both the public at large and the EMS providers as in the event of an emergency incident, resources may be difficult to activate. As technological advances are made, these areas will become smaller and smaller.

b. Dispatch:

Three of the four counties currently provide their dispatchers with some type of EMD training. The fourth county, Douglas, has a small dispatch center. The option for EMD training is currently available only outside the area, and would require an overnight stay of varying length. With a limited number of dispatchers, sending even one away would put a burden on the remaining dispatchers. The cost of overtime needed to cover during training, the training itself, and the travel expenses would be a financial burden for the agency.

None of the agencies has had specific training in dispatch prioritizing or provision for bystander care with dispatch assistance. Each county does both prioritization and assistance of some sort. All counties agreed that a more EMS-oriented dispatch training option would be very helpful. For this reason, the Region has looked at available options, and selected King County's Criteria Based Dispatch Program as the best of the options. This program will also train trainers in the Region, allowing us to offer the training on a local level. The Communications Committee is looking at implementing training in this program in the region.

c. Primary and alternative communications systems.

The primary communication system in the Region is the radio frequency. Each county has at least one dedicated dispatching frequency for each of their public service entities.

Agencies are alerted using a varied mix of Tone Voice Paging devices and/or Alpha Pagers. Those agencies that use pagers of either type also use either portable or mobile radios to acknowledge the page, communicate with hospital emergency departments and to communicate with the dispatch center. During times of crisis and mutual aid most agencies have opted to cross program their radio equipment there-by allowing for multi-agency communications on dedicated frequencies. In addition, there are countywide emergency management frequencies used when needed.

Alternative communications systems would include other agency dedicated communication frequencies. For instance, most ambulance and aid agencies have both the Law Enforcement LEARN frequency and the Hospital HEAR frequency on vehicle radios and some portable radios. Cell phones are used primarily for communication with medical control.

d. A discussion of system operation during single patient, multiple-patient, mass casualty and disaster incidents, identifying ambulance to ambulance, ambulance to dispatch, and ambulance to hospital communications systems

Single Patient incident – The call would be received at the dispatch center via 911 or enhanced 911, the call taker/dispatcher would receive the pertinent information, then tone out the agencies necessary to respond on the appropriate dispatch frequencies, the agency would acknowledge the page and all responding units would check in route with the dispatch center, dispatch would provide updated information as they receive it. The arriving unites would in turn check out on the scene with the dispatch center. After scene operations, the transporting ambulance would check in route with dispatch to the hospital, the transporting ambulance would then make radio contact with the receiving hospital on the HEAR radio system for patient report, the transporting ambulance would check out at the receiving hospital with the dispatch center. All remaining unites and the transport ambulance when again available for calls would notify the dispatcher of their status.
Multiple patient incident – These are handled in the same manner as a single patient incident with the primary exception being that more than one transport unit or multiple transport agencies would be notified depending on the scope of and nature of the incident.
Mass Casualty incidents – Same as above, the MCI protocol would be instituted and all agencies would be dispatched.
Disaster incidents – Will be handled in the same manner as an MCI, with the addition of statewide resources.

e. Roles of other public and private agencies, e.g., police to fire to ambulance.

The roles of ancillary support agencies vary, but the communications between agenciesis accomplished using the ICS (incident command system) thereby coordinating all communications through designated command posts and their respective frequencies. Interagency communications between support agencies and EMS agencies is accomplished via the LEARN frequency which is available to all emergency response agencies within the region.

f. Evaluating communication system providers and dispatch activities using the attached Table A.

TABLE A Communications Centers Survey List by County	1. Citizen Access	2. Consolidated	3. No. Employed	4. No. Not Trained	5. Kinds of Training & How Often	6. On-going Training	7. Kinds of Protocols	8. Med. Director involvement	9. Dispatch Prioritizing	10. Bystander Care	11. Pre-arrival Instructions	12. Quality Assurance
Grant County MACC	Yes	Yes	12	10	EMD	Yes		No	Yes	Yes	Yes	Yes
					2 YRS							
Douglas County	Yes	Yes	5	0	NONE	No		No	Yes	No	Yes	No
Okanogan County	Yes	Yes	12	9	EMD	No		No	Yes	No	Yes	No
					2 YRS							
Chelan Co. Sheriff	Yes	No	10	0	NONE	No		No	Yes	No	Yes	Yes
Chelan Police Dept	Yes	No	5	2	EMD	No		No	Yes	No	Yes	Yes
					2 YRS							
Wenatchee Police/Fire/EMS	Yes	Yes	13	13	EMD	No		No	Yes	No	Yes	Yes
					2 YRD							

2. **Strengths and Weaknesses:** Discuss the strengths and weaknesses of the current system to include an assessment of additional needs within the region.

Strengths: Overall, the Region has a manageable communications system. There are no documented incidents of agencies not receiving their notification of response. As is inherent in all radio communications, there are areas within the region that prevent good communications. This are becoming more evident has incident numbers increase and will be monitored to determine need. Because of terrain features, there will always be areas where communications could be improved. With mountain valleys and coulees, the ability to communicate "everywhere" in the region is not a realistic goal. The regional council is aware of areas within the region that need improved communications but those areas are small in number and size and will be evaluated to determine if it will be cost effective to upgrade existing systems or if the expense is justifiable.

Weaknesses: As for weaknesses, EMD training that is cost-effective on a local level, and EMS-oriented is a critical need. The Region has identified the King County program as the best to meet our need for local trainers. The Region, through their Communications Committee, will need to offer support to attempt to accomplish these improvements. Medical Director involvement is limited within the regions communications system and this shortfall will be address during this biennium.

The Communications Committee has also identified certain areas of concern. While these areas of concern do not qualify as "weaknesses" that need to be addressed by this plan, neither should they be forgotten. These are arranged in order of priority, with some possible solutions:

1. In Chelan and Douglas Counties, there is an area that needs review and possible revision. This entails the dispatching of aid agencies by one county dispatch center and the transport agencies by another county dispatch center. Once the transport agency leaves the lower Wenatchee Valley, their primary channel does not reach the aid agencies. A practical solution to this problem would be to equip responding ambulances with 100-watt multi channel capacity radios. These could be programmed with the fire repeater, sheriff office and HEAR base station channels. This would allow the transporting agencies to use existing repeaters to minimize "dead spots" in the canyons.

2. The region has a number of small, financially burdened agencies. The need for replacement radios and pagers is ongoing. This is not an area where funding is readily available. Most sources of grant funding exclude communications equipment such as this. The region will be exploring funding opportunities for these agencies

3. The Gorge area of Grant County draws crowds of at least 18-20,000 people, regularly, to the concerts held there. Because of the terrain in the area, communications with Medical Control and dispatch agencies are not optimal. The Multi-Agency Communications Center in Grant County is looking at options to solve the problems in this area. Here, the Region just needs to be aware of MACC's efforts. In the event a solution cannot be found, the Region may need to offer help.

4. The area between Pateros and Chelan along Hwy 97 has long been an area where communications between ambulances responding to the same call are difficult. This is another area where terrain is the problem. This may be an area where radio

repeaters and/or towers could benefit. No statistical data is available to support this ascertain

5. The need for a satellite phone on the North Cascades Highway on either Washington or Rainy Passes or both, has been identified

Demographics:

a. Identify specific demographics of the region that impact communications system development in the region.

Increased use of the "cross-state highway" has identified the need for some type of citizen accessible communications for emergency response the North Cascades Highway. The addition of a satellite phone on the North Cascades Highway on either Washington or Rainy Passes or both would be of benefit to travelers of that highway as cell phone reception does not exist and communications of any type is problematic.

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4. Goals: List the Regional EMS/TC system's goals, objectives, strategies and projected costs to improve the communications system to build on the strengths and mitigate the weaknesses of the current system.

Goals:

1. Train 4 – 6 EMS personnel as EMD instructors.
2. Have all EMS dispatchers in the region receive EMD training.
3. Install a repeater or cell tower between Pateros and Chelan along Hwy 97A where communications between ambulances responding to the same call are difficult.

Objectives:

1. Look for funding sources for EMD instructor training for 23 dispatchers and paramedics.
2. Fund EMD training for all Communications Centers within the region.
3. Look for funding sources to install either a repeater or cell tower between Pateros and Chelan along Hwy 97A.
4. Look for funding source for a satellite phone on the North Cascades Highway.

Cost:

1. EMD Instructors Training = $ 5000.00
2. EMD training for dispatchers = $10500.00
3. Communications Equipment = $120000.00

Strategies:

At this time no specific strategy has been identified to fulfill the above objectives. An identified barrier is funding.

B. Medical Direction of Pre-Hospital Providers: Discuss the system of off-line and on-line medical direction. Discuss the strengths and weaknesses of the current system, and list the Regional EMS/TC system's goals, objectives, strategies and projected costs to improve the medical direction within the system.

Currently all agencies in the Region have County MPD Protocols to use for medical direction off-line. Due to areas within the region with limited radio and cell phone coverage, EMS providers in the North Central Region rely on off-line medical direction in many cases. The MPD Protocols give very distinct direction

and are vital to the delivery of emergency medical care in our rural areas. Where adequate communications allow, on-line medical direction is used to supplement the MPD Protocols. The Medical Program Directors are working together in an attempt to develop MPD Protocols for use throughout the region..

Goals:

1. Encourage and assist in the development of Regional MPD Protocols
2. Increase MPD Protocol understanding among EMS providers

Objectives:

1. Have regional MPD Protocols in place by end of fiscal 2002.
2. Incorporate MPD Protocol education in current education system in place in the region

Costs:

1. MPD Protocols (development, printing & distribution) = $ 1000.00
2. Protocol Education (training of EMS personnel) = $ 1500.00

Strategies:

The Regional Council Office is working with the MPDs in coordinating meetings, printing and distribution of MPD Protocols as necessary and will continue with that process.
The Regional Council will consider amending the contract with the Inland Empire Training Council to include protocol education in their curriculum. The added cost of the proposed contract amendment may be a barrier.

C. Pre-Hospital EMS and Trauma Services:

1. **Current Status:** Describe available resources, configuration, staffing, and service levels of current prehospital services.

a. Current EMS/TC Personnel Resources: Identify the EMS and trauma care workforce resources available within the region, by county, to include all levels of prehospital personnel. Numbers were provided by DOH on 05/03/2001.

	FR	EMT-B	IV	IV/AW	IL	IL/AW	EMT-P	Total
Chelan County:								
Paid	**2**	**75**	**22**	**0**	**0**	**0**	**27**	**126**
Volunteer	**33**	**116**	**17**	**1**	**0**	**0**	**1**	**168**
Douglas County:								
Paid	**6**	**2**	**2**	**0**	**0**	**0**	**0**	**10**
Volunteer	**24**	**58**	**5**	**0**	**0**	**0**	**0**	**87**
Grant County:								
Paid	**13**	**27**	**7**	**0**	**0**	**1**	**11**	**59**
Volunteer	**59**	**137**	**6**	**1**	**3**	**13**	**2**	**221**
Okanogan County:								
Paid	**2**	**20**	**1**	**0**	**1**	**2**	**3**	**29**
Volunteer	**8**	**119**	**4**	**0**	**1**	**8**	**1**	**141**

Grand Totals:								
Paid	**23**	**124**	**32**	**0**	**1**	**3**	**41**	**224**
Volunteer	**124**	**430**	**32**	**2**	**4**	**21**	**4**	**617**

Current Number of Verified EMS Services by County in the Region

	AID			AMBULANCE		
	BLS	**ILS**	**ALS**	**BLS**	**ILS**	**ALS**
Chelan	**5**	**0**	**0**	**2**	**0**	**4**
Douglas	**1**	**0**	**0**	**3**	**0**	**0**
Grant	**6**	**0**	**0**	**7**	**1**	**2**
Okanogan	**2**	**0**	**0**	**4**	**1**	**1**

b. Prehospital Training Resources: Identify available training resources for all levels of prehospital EMS/TC personnel.

The North Central Region contracts with the Inland Empire Training Council to provide CME/OTEP training for all agencies in the region. On average the Training Council conducts well over 100 classes per year within our region. Over 1750 students total attend these classes annually. The classes are given throughout the region to limit the number of miles providers must travel to meet their training requirements. The class locations are as follows:

Chelan County-

Wenatchee	Stehekin	Leavenworth
Sunnyslope	Chelan	

Douglas County

Bridgeport	Mansfield	Waterville

Grant County

Grant County FD #5	Ephrata	Soap Lake
Grand Coulee	Coulee City	Quincy
Wilson Creek	Hartline	Mattawa
Royal City	Warden	

Okanogan County

Inchelium	Brewster	Twisp
Okanogan	Ellisford	Nespelem

On average, students attending the classes at the various locations around the region, traveled 5.25 miles from home. This is most certainly a goal of the region to limit the travel distance for our providers to attend OTEP/CME classes.

Initial FR and EMT classes are conducted at Wenatchee Valley College twice a year and various classes are held throughout the region sponsored by numerous EMS agencies.

c. Prioritizing and Conducting Prehospital Training: Discuss the need for training to maintain existing level of personnel and to add needed personnel to the system, including a discussion of strategies for prioritizing and securing needed prehospital personnel training.

The following are some of the areas of concern:

Due to the time and travel involved away from family and work-related commitments, the expense, both socially and economically to the volunteer provider, is significant.

The cost of either sponsoring or attending an EMT or FR class is at times prohibitive for the volunteer agency or personnel.

Currently, ALS courses are provided by the agency needing the classes. It is a goal of the region to help provide classes to the ALS agencies in a manner that will include as many agencies and providers as possible.

Long travel distances and hazardous winter travel conditions impact the amount of training some areas receive, the region will be looking into the possibility of using telecommunications, (i.e., telemedicine) to provide training more efficiently and at a cost savings.

Recognizing the struggle to recruit, train, maintain and retain volunteers, the North Central Regional Council will continue to be committed to providing assistance and resources to assist the affected EMS agencies in our region.

Numerous surveys and questionnaires are distributed to ascertain the priority and needs of the EMS providers. The results of these surveys drive the direction to which the region goes with its training schedule.

d. Additional Public Safety Personnel Role and Availability: Discuss the roles and availability of other public safety personnel within the region (law enforcement, SAR, military, etc.).

Throughout the North Central Region, we are very fortunate to have a good working relationship with a large contingency of Public Safety entities that provide an invaluable service to the EMS system in the areas of; safety, scene command, extrication, search and

rescue, water rescue, confined space rescue, BLS first response, fire suppression, Clandestine Drug Lab Removal, scene assistance, mass evacuation, emergency housing and additional man power as needed.

The following are the Public Safety entities that assist our EMS system in the North Central Region:

Washington State Patrol	County Sheriff Departments
Local city police and fire departments	US Forest Service
US Park Service	County Search and Rescue
Military Air Rescue	County Fire Departments
Local Transit Authorities	

Without the assistance of these vital entities, our EMS system would be hard pressed to have the total coverage we now enjoy. On countless occasions, these Public Safety personnel have contributed and assisted the EMS response.

2. **Strengths and Weaknesses:** Discuss the strengths and weaknesses of these programs including an assessment of additional personnel and training needs within the region.

The following are seen as strengths:

- It has been noted by many agencies via our surveys, that a significant problem exists regarding the maintaining of an adequate number of prehospital providers in our rural areas, particularly for our volunteer agencies. The reasons for low numbers of personnel are varied, but most often can be attributed to the amount of time the EMS commitment requires, lack of funding to reimburse volunteers for time & mileage. It can be reasonably assumed that improvement of the rural system of EMS and trauma care can be increased by raising the skill level of those currently providing BLS services and reducing the rate of attrition.
- Even though they are still licensed as BLS agencies, Quincy Valley Ambulance, Royal Slope EMS, Soap Lake Ambulance, Grant County Fire District #8 and Okanogan County Fire District #5 have all trained personnel in Intermediate care, as IV Technician, Intermediate Life Support Technicians, and/or as Intermediate Life Support/Airway Technicians.

Weaknesses would include:

- We have limited Search and Rescue groups. With the number of lakes and rivers in the region, it would be beneficial to all agencies to have more training in water rescue.
- Due to limited populations throughout the region, it is difficult to support ALS ambulance services, ILS training for agencies in the areas of Grand Coulee, Mattawa, Quincy, Royal City, the Coulee City/Hartline area, Brewster, Waterville, Tonasket, Oroville, Colville Tribal Services area and Mansfield would be beneficial.
- Aid agency coverage could be improved. We have a small number of agencies that have yet to commit to providing EMS aid response.
- Recreation in the North Central Region brings a significant change in demographics to areas of the region such as the Lake Chelan, Twisp/Winthrop, Leavenworth, the Gorge at George, the two Off Road Vehicle parks, Banks Lake, and Sun Lakes.

3. **Demographics:** Identify specific demographics of the region that may drive the expansion of the existing prehospital personnel and training personnel and training, such as population by age and gender:

Response from our regional agencies indicates the most frequent requests for additional training from those in the field are:

Wilderness and Water Safety Rescue training,
Increase the number of trained personnel to respond in the rural communities
Due to the agriculturally based communities the need for more Farmedic classes
Environmental emergency and critical care transport trainings is also requested

4. **Goals**: Identify the Regional EMS/TC system's long term and short-term goals, objectives, strategies and projected costs to improve the overall Pre-Hospital EMS and Trauma Services in the region.

Short Term Goals

Assist and encourage all city/county fire departments to provide, at least, BLS aid service.

Address inter-agency training issues regarding ALS and Paramedic continuing education.

Continue to improve the CME/OTEP training currently provided by the Inland Empire Training Council

Address inter-agency training issues regarding ALS and Paramedic continuing education that will keep them in compliance with regulations regarding verification.

Assist Local Councils in providing initial training for EMTs and FRs

Long Term Goals

Support all EMTs in pursuit of specialized skills such as IV Tech, Airway management and ILS skills

Encourage existing BLS services to upgrade their certification level to ILS, if ALS services cannot be supported

Develop an evaluation program for the purposes of measuring the effectiveness of the existing training and continuing education programs.

Pursue funding for ALS and Paramedic training within the region, to keep the providers in compliance with verification requirements.

Objectives

Over the biennium, the region will work with provider agencies and local councils to identify agencies and personnel that wish to upgrade their skill level. Once they are identified, the region will assist them with the process of gaining the knowledge and meeting the requirements necessary to attain that upgrade.

Seek alternative sources of funding and activities, which will provide necessary educational opportunities for all EMS providers.

Strategies

The region will be hosting an EMS conference, we hope to provide avenues for EMS providers and nurses to get additional education not easily found in the region

Projected Costs

It is estimated that the EMS conference will cost approximately $50,000. These funds will be received from sponsors, vendors, and conference participants.

D. Verified Aid and Ambulance Services:

1. **Current Status:**

a. Identify the current Prehospital Response Areas (urban, suburban, rural, and wilderness) in each county. County response area tables.

b. Provide an assessment of the need for and distribution of services within the region as defined in RCW 70.168.100(1)(h). Discuss the current Regional process for determining need and distribution within each county in the region.

Each Local EMS and Trauma Care Council evaluated current EMS services and service area coverage to determine minimum and maximum levels of service. Each local council evaluated the need for further services and the recommendations for change, if any, were sent forward to the Regional Council. Only the Grant County Local Council found a need for additional services within the county, which are enclosed in Table B. These changes are reflected in this plan as changes in the min/max numbers.

The local council following procedures, forwarded their recommendations to the Regional Council for review and recommendation to the Washington State Department of Health. During this process, it was noted that a number of EMS agencies were interested in increasing their license and verification status, advancing from BLS to ILS, ILS to ALS status.

The Regional Council will be considering a process for adding or changing existing boundaries and establishing tiered response service areas within the North Central Region.

RCW 70.168.100 (1) (h) states that Regional EMS/TC councils shall "Identify the need for and recommend distribution and level of care of prehospital services to assure adequate availability and avoid inefficient duplication and lack of coordination of prehospital services within the region;"

WAS 246-976-960 (1) (b) (i) states that "in addition to meeting the requirements of chapter 70.168 RCW and elsewhere in this chapter, regional EMS/TC councils must: Identify the need for and recommend distribution and level of care (basic, intermediate or advanced life support) for verified aid and ambulance services for each response area. <u>The recommendations will be based on criteria established by the department relating to agency response times, geography, topography, and population density;"</u>

Currently, there are no clear criteria relating to agency response times, geography, topography, and population density established by the department for identifying the need for and recommending distribution and level of care for verified aid and ambulance services. The North Central Regional Council has used recommendations by the local councils; various data elements and it own expertise to determine the need for and distribution of services.

a. Identify the current Prehospital Response Areas (urban, suburban, rural, and wilderness) in each county. County response area tables

Geo-Political Area	Chelan County Geo-Political Areas used to identify the response of Trauma Verified Services to *Major Trauma Incidents (*As defined by the Trauma Triage Tool)
Chelan County Fire Dist. #1 (Rural)	Chelan County Fire Dist. #1 proper – Maps and/or description available at Regional Office
Chelan County Fire Dist #3 (Rural)	Chelan County Fire Dist. #3 proper – Maps and/or description available at Regional Office
Chelan County Fire Dist #4 (Rural/Wilderness)	Chelan County Fire Dist. #4 proper – Maps and/or description available at Regional Office
Chelan County Fire Dist. #5 (Rural/Wilderness)	Chelan County Fire Dist. #5 proper. Maps and/or description available at Regional Office.
Chelan County Fire Dist. #6 (Rural/Wilderness)	Chelan County Fire Dist. #6 proper. Maps and/or description available at Regional Office.
Chelan County Fire Dist #8 (Rural/Wilderness)	Chelan County Fire Dist. #8 proper – Maps and/or description available at Regional Office
City of Cashmere (Rural)	City limits of Cashmere proper. Map and/or description available at Regional Council Office.
City of Wenatchee (Suburban)	City limits of Wenatchee proper. Maps and/or description available at Regional Council Office
National Park Service- Stehekin (Wilderness)	Town of Stehekin and surrounding wilderness area. Maps and/or description available at Regional Council Office.

Only cities that maintain their own EMS service were identified as a geo-political response area all others are fire districts.

b. Provide an assessment of the need for and distribution of services within the region as defined in RCW 70.168.100(1)(h).

Chelan County

Need	Distribution of Verified Trauma Services
Chelan County FD #1 BLS Aid ALS Transport	 BLS Aid - Chelan Co. FD #1 ALS Transport - Ballard Ambulance Services, LifeLine Ambulance Inc.
Chelan County FD #3 BLS Aid BLS Transport ALS Transport	 BLS Aid – Chelan Co. FD #3 BLS Transport - Not Currently Provided (#1) ALS Transport – Cascade Ambulance Service
Chelan County FD #4 BLS Aid BLS Transport ALS Transport	 BLS Aid – Chelan Co. FD #4 BLS Transport - Not Currently Provided (#1) ALS Transport – Cascade Ambulance Service
Chelan County FD #5 ALS Transport	 ALS Transport - Lake Chelan EMS
Chelan County FD #6 BLS Aid (a) BLS Transport ALS Transport	 BLS Aid - Dryden Fire Department (Peshastin FD Licensed Only) (#2) BLS Transport - Cashmere Fire Department ALS Transport – Cascade Ambulance Service, Ballard Ambulance Services, LifeLine Ambulance Inc.
Chelan County FD #7 ALS Transport	 ALS Transport - Lake Chelan EMS
Chelan County FD #8 BLS Transport ALS Transport	 BLS Transport - Chelan Co. FD #8 ALS Transport - Ballard Ambulance Service, Lake Chelan EMS
Cashmere, City of BLS Transport ALS Transport	 BLS Transport - Cashmere Fire Department ALS Transport - Ballard Ambulance, LifeLine Ambulance
Wenatchee, City of BLS Aid ALS Transport	 BLS Aid - Wenatchee Fire Department ALS Transport - Ballard Ambulance & LifeLine Ambulance
National Park – Stehekin BLS Aid ALS Transport	 BLS Aid - Lake Chelan EMS ALS Transport – Northwest MedStar, Lake Chelan EMS

Chelan County Unmet needs;

1. Within the boundaries of Chelan County FD #3, and #4, there is a need for verified BLS transport due to the sometimes-lengthy response by the nearest ambulance.
2. The Chelan County FD #6 response area is in need of a verified BLS agency. The region will attempt to assist Peshastin Fire Department to become a trauma verified BLS aid agency. They are currently licensed as aid only.

Using the attached Table B., For each county, specify in the appropriate columns

TABLE B

Min/Max Numbers for Verified Trauma Services*

NORTH CENTRAL REGION CHELAN COUNTY

6/30/2001

Services	No Change In Status	Number Currently Verified	Minimum Number		Maximum Number	
			Approved	Recommend	Approved	Recommend
AID						
BLS	**X**	**5**	**4**	**4**	**6**	**6**
ILS	**X**	**0**	**0**	**0**	**0**	**0**
ALS	**X**	**0**	**0**	**0**	**0**	**0**
AMBULANCE						
BLS	**X**	**2**	**2**	**2**	**4**	**4**
ILS	**X**	**0**	**0**	**0**	**0**	**0**
ALS	**X**	**4**	**4**	**4**	**4**	**4**

*** As identified in the approved regional response plan.**

a. Identify the current Prehospital Response Areas (urban, suburban, rural, and wilderness) in each county. County response area tables.

Geo-Political Area	**Douglas County Geo-Political Areas used to identify the response of Trauma Verified Services to *Major Trauma Incidents (*As defined by the Trauma Triage Tool)**
Douglas County Fire Dist. #1 (Suburban/Rural)	Douglas County Fire Dist. # 1 proper – Map and description available at Regional Council Office.
Douglas County Fire Dist. #2 (Suburban/Rural)	Douglas County Fire Dist. # 2 proper – Map and description available at Regional Council Office.
Douglas County Fire Dist. #3 (Suburban/Rural)	Douglas County Fire Dist. # 3 proper – Map and description available at Regional Council Office.
Douglas County Fire Dist #4 (Rural)	Douglas County Fire Dist. # 4 proper – Map and description available at Regional Council Office.
Douglas County Fire Dist. #5 (Suburban/Rural)	Douglas County Fire Dist. # 5 proper – Map and description available at Regional Council Office.
Douglas County Fire Dist. #6 (Suburban/Rural)	Douglas County Fire Dist. # 6 proper – Map and description available at Regional Council Office.
Douglas County Fire Dist. #7 (Suburban/Rural)	Douglas County Fire Dist. # 7 proper – Map and description available at Regional Council Office.
City of Bridgeport (Rural)	City Limits of Bridgeport proper. Map and description available at Regional Council Office.

Only cities that maintain their own EMS service were identified as a geo-political response area all others are fire districts.

b. Provide an assessment of the need for and distribution of services within the region as defined in RCW 70.168.100(1)(h).

Douglas County

Need	Distribution of Trauma Verified Services
Douglas County FD #1 BLS Transport ALS Transport	BLS Transport – Waterville Ambulance Service, Mansfield Volunteer Fire Department ALS Transport - Ballard Ambulance Service, LifeLine Ambulance Inc.
Douglas County FD #2 BLS Aid ALS Transport	BLS Aid – Douglas Co. FD #2 ALS Transport - Ballard Ambulance Service, LifeLine Ambulance Inc.
Douglas County FD #3 BLS Aid BLS Transport	BLS Aid - Not Currently Provided (#1) BLS Transport - Bridgeport Ambulance Service, Mansfield Volunteer Fire Department, Grand Coulee Fire Department
Douglas County FD #4 BLS Aid (a) BLS Transport ALS Transport	BLS Aid - Not Currently Provided (Douglas FD #4 Licensed Only) (#1) BLS Transport - Waterville Ambulance Service, Mansfield Volunteer Fire Department ALS Transport - Ballard Ambulance Service, LifeLine Ambulance Inc., Lake Chelan EMS
Douglas County FD #5 BLS Transport ALS Transport	BLS Transport - Mansfield Volunteer Fire Department, Bridgeport Ambulance Service ALS Transport - Lake Chelan EMS
Douglas County FD #6 BLS Transport	BLS Aid - Not Currently Provided (#1) BLS Transport - Brewster Ambulance Service
Douglas County FD #7 BLS Aid BLS Transport	BLS Aid - Not Currently Provided (#1) BLS Transport - Bridgeport Ambulance Service, Mansfield Volunteer Fire Department
City of Bridgeport BLS Transport	BLS Transport – Bridgeport Ambulance Service

Douglas County Unmet needs;

1. Within the boundaries of Douglas County FD #3, #4, #6 & #7,there is a need for BLS aid due to the sometimes-lengthy response by the nearest ambulance.

Using the attached Table B., For each county, specify in the appropriate columns

TABLE B

Min/Max Numbers for Verified Trauma Services*

NORTH CENTRAL REGION DOUGLAS COUNTY

6/30/2001

Services	No Change In Status	Number Currently Verified	Minimum Number		Maximum Number	
			Approved	Recommend	Approved	Recommend
AID						
BLS	X	1	1	1	5	5
ILS	X	0	0	0	0	0
ALS	X	0	0	0	0	0
AMBULANCE						
BLS	X	3	3	3	4	4
ILS	X	0	0	0	1	1
ALS	X	0	0	0	0	0

* As identified in the approved regional response plan.

a. Identify the current Prehospital Response Areas (urban, suburban, rural, and wilderness) in each county.

County response area tables.

Geo-Political Area	Grant County Geo-Political Areas used to identify the response of Trauma Verified Services to *Major Trauma Incidents (*As defined by the Trauma Triage Tool)
Grant County Fire Dist #3 (Rural)	Grant County Fire Dist. # 3 proper – Map and description available at Regional Council Office.
Grant County Fire Dist #4 (Rural)	Grant County Fire Dist. # 4 proper – Map and description available at Regional Council Office.
Grant County Fire Dist #5 (Suburban/Rural)	Grant County Fire Dist. # 5 proper – Map and description available at Regional Council Office.
Grant County Fire Dist #6 (Rural)	Grant County Fire Dist. # 6 proper – Map and description available at Regional Council Office.
Grant County Fire Dist #7 (Rural)	Grant County Fire Dist. # 7 proper – Map and description available at Regional Council Office.
Grant County Fire Dist #8 (Rural/Wilderness)	Grant County Fire Dist. # 8 proper – Map and description available at Regional Council Office.
Grant County Fire Dist #10 (Rural/Wilderness)	Grant County Fire Dist. # 10 proper– Map and description available at Regional Council Office.
Grant County Fire Dist #11 (Rural/Wilderness)	Grant County Fire Dist. # 11 proper– Map and description available at Regional Council Office.
Grant County FPD #12 (Rural/Wilderness)	Grant County Fire Dist. # 12 proper – Map and description available at Regional Council Office.
Grant County Fire Dist #13 (Rural/Wilderness)	Grant County Fire Dist. # 13 proper– Map and description available at Regional Council Office.
Grant Count Fire Dist. # 14 (Rural/Wilderness)	Grant County Fire Dist. # 14 proper– Map and description available at Regional Council Office.
Grant County Fire Dist #15 (Rural/Wilderness)	Grant County Fire Dist. # 15 proper– Map and description available at Regional Council Office.

Geo-Political Area	**Grant County Geo-Political Areas used to identify the response of Trauma Verified Services to *Major Trauma Incidents (*As defined by the Trauma Triage Tool)**
City of Coulee City (Rural)	City limits of Coulee City proper – Map and description available at Regional Council Office.
City of Ephrata (Rural)	City limits of Ephrata proper – Map and description available at Regional Council Office.
City of Grand Coulee (Rural)	City limits of Grand Coulee proper – Map and description available at Regional Council Office.
City of Moses Lake (Suburban)	City of Moses Lake proper – Map and description available at Regional Council Office.
City of Soap Lake (Rural)	City limits of Soap Lake – Map and description available at Regional Council Office.
Port of Moses Lake (Rural)	Port district boundaries. Grant County International Airport & Surrounding Industries – Map and description available at Regional Council Office.

Only cities that maintain their own EMS service were identified as a geo-political response area all others are fire districts.

b. Provide an assessment of the need for and distribution of services within the region as defined in RCW 70.168.100(1)(h).

Grant County

Need	Distribution of Trauma Verified Services
Grant County FD #3 BLS Aid BLS Transport ALS Transport	 BLS Aid - Grant Co. FD #3 BLS Transport - Quincy Valley Ambulance & Grant Co. FD # 10 ALS Transport - Ephrata Ambulance Service (Parts of Fire Dist. #3 Map and description available at Regional Council Office.) (Total ALS coverage is desired by Regional Council see below)
Grant County FD #4 BLS Aid ILS Transport ALS Transport	 BLS Aid – Grant Co. FD #4 ILS Transport - Central Grant Medic One ALS Transport- Moses Lake Fire Department
Grant County FD #5 BLS Aid BLS Transport ILS Transport ALS Transport	 BLS Aid - Not Currently Provided (Grant Co. #5 Licensed Only) BLS Transport - Grant Co. FD #10 ILS Transport - Central Grant Medic One ALS Transport - Moses Lake Fire Department (partial coverage), Ephrata Ambulance Service (partial coverage)
Grant County FD #6 BLS Transport ILS Transport	 BLS Transport - Grant Co. FD #6, Coulee City Fire Department, Grand Coulee FD ILS Transport - Not Currently Provided
Grant County FD #7 BLS Aid BLS Transport ILS Transport ALS Transport	 BLS Aid - Grant Co. FD #7 BLS Transport - Partial Coverage Coulee City Fire Department & Grant Co. FD #6 ILS Transport - Central Grant Medic One (partial coverage) ALS Transport - Ephrata Ambulance Service (partial coverage)
Grant County FD #8 BLS Transport ILS Transport ALS Transport	 BLS Transport - Grant Co. FD #8 ILS Transport - Not Currently Provided ALS Transport - Not Currently Provided
Grant County FD #10 BLS Transport ILS Transport ALS Transport	 BLS Transport - Grant Co. FD #10 & Grant Co. FD #8 ILS Transport - Not Currently Provided) ALS Transport - Not Currently Provided
Grant County FD #11 BLS Transport ILS Transport	 BLS Transport - Grant Co. FD #10 ILS Transport - Not Currently Provided
Grant County FD #12 BLS Aid BLS Transport ILS Transport ALS Transport	 BLS Aid - Not Currently Provided (Grant Co. #12 Licensed Only) BLS Transport - Partial Coverage by Coulee City Ambulance & Grant Co. FD #6 ILS Transport - Central Grant Medic One ALS Transport - Ephrata Ambulance Service
Grant County FD #13 BLS Aid ALS Transport	 BLS Aid - Not Currently Provided ALS Transport - Ephrata Ambulance Service
Grant County FD #14 BLS Aid BLS Transport	 BLS Aid - Not Currently Provided BLS Transport – Grand Coulee Fire Department

Grant County

Need	Distribution of Trauma Verified Services
Grant County FD #15	
BLS Aid	BLS Aid - Not Currently Provided (Grant Co. #5 Licensed Only)
BLS Transport	BLS Transport - Partial Coverage by Grant Co. FD #10
ILS Transport	ILS Transport – Central Grant Medic One
ALS Transport	ALS Transport - Ephrata Ambulance Service (partial coverage), Moses Lake Fire Department (partial coverage)
Coulee City, City of	
BLS Transport	BLS Transport – Coulee City Fire Department
Ephrata, City of	
BLS Aid	BLS Aid - Not Currently Provided
ALS Transport	ALS Transport - Ephrata Ambulance Service
Grand Coulee, City of	
BLS Transport	BLS Transport - Grand Coulee Fire Department
ILS Transport	ILS Transport - Not Currently Provided
Moses Lake, City of	
ILS Transport	ILS Transport - Central Grant Medic One
ALS Transport	ALS Transport - Moses Lake Fire Department
Port of Moses Lake	
BLS Aid	BLS Aid - Port of Moses Lake Fire Department
ILS Transport	ILS Transport - Central Grant Medic One
ALS Transport	ALS Transport - Moses Lake Fire Department
Soap Lake, City of	
BLS Aid	BLS Aid - Not Currently Provided
BLS Transport	BLS Transport - Soap Lake Ambulance Service
ALS Transport	ALS Transport - Ephrata Ambulance Service

Grant County unmet needs;

*Within the response area of Grant County FD #3, there exists a need for a verified ALS transport service due to the distance of the nearest verified ALS responder. Grant County is also the third fastest growing county in the state.

There is also a need for verified ILS transport services in the response areas of Grant County FD #8, Grant County FD #10, Grant County FD #3, City of Grand Coulee and either Coulee City or Grant County FD #6, due to the distance and length of response of the nearest verified ILS or higher service.

Within the boundaries of Grant County FD #12, there is a need for a verified BLS transport service, due to the distance of the nearest ambulance.

In the response areas of the City of Ephrata and Grant County FD #13, there exists a need for verified BLS aid response due to the assistance and response that these services can provide to augment the existing ALS services. In the response areas of Grant Co. FD #5, #12 and #14, it is recommended that the agencies serving that area with an aid service be trauma verified.

Using the attached Table B., **For each county, specify in the appropriate columns**

TABLE B

Min/Max Numbers for Verified Trauma Services*

NORTH CENTRAL REGION GRANT COUNTY

SERVICES	STATE APPROVED		CURRENT STATUS
	MIN	MAX	
ADD:			
BLS	4	11	4
ILS	0	0	0
ALS	0	0	0
ADIB:			
BLS	4	8**	7
ILS	1	5**	1
ALS	1	3***	2

* As identified in the approved regional response area plan.

** Any increase in service level to ILS will drop the corresponding maximum number of BLS ambulance services.

*** ALS verified services limited to three response areas (Moses Lake, Ephrata, Quincy).

FY 02/03 Regional Plan
DOH Approval Date 02/04/02

a. Identify the current Prehospital Response Areas (urban, suburban, rural, and wilderness) in each county.
County response area tables

Geo-Political Area	Okanogan County Geo-Political Areas used to identify the response of Trauma Verified Services to *Major Trauma Incidents (*As defined by the Trauma Triage Tool)
Okanogan County Fire Dist #1 (Rural)	Okanogan County Fire Dist. #1 proper. Map and/or description available at Regional Council Office.
Okanogan County Fire Dist #3 (Rural)	Okanogan County Fire Dist. #3 proper. Map and/or description available at Regional Council Office.
Okanogan County Fire Dist #4 (Rural)	Okanogan County Fire Dist. #4 proper. Map and/or description available at Regional Council Office.
Okanogan County Fire Dist #5 (Rural)	Okanogan County Fire Dist. #5 proper. Map and/or description available at Regional Council Office.
Okanogan County Fire Dist #6 (Rural)	Okanogan County Fire Dist. #6 proper. Map and/or description available at Regional Council Office.
Okanogan County Fire Dist #7 (Rural)	Okanogan County Fire Dist. #7 proper. Map and/or description available at Regional Council Office.
Okanogan County Fire Dist #8 (Rural)	Okanogan County Fire Dist. #8 proper. Map and/or description available at Regional Council Office.
Okanogan County Fire Dist #9 (Rural)	Okanogan County Fire Dist. #9 proper. Map and/or description available atRegional Council Office.
Okanogan County Fire Dist #10 (Rural)	Okanogan County Fire Dist. #10 proper. Map and/or description available at Regional Council Office.
Okanogan County Fire Dist #11 (Rural)	Okanogan County Fire Dist. #11 proper. Map and/or description available at Regional Council Office.
Okanogan County Fire Dist #12 (Rural)	Okanogan County Fire Dist. #12 proper. Map and/or description available at Regional Council Office.
Colville Tribal Reservation (Rural/Wilderness)	Colville Tribal Reservation – Map and/or description available at Regional Council Office.

Only cities that maintain their own EMS service were identified as a geo-political response area all others are fire districts.

b. Provide an assessment of the need for and distribution of services within the region as defined in RCW 70.168.100(1)(h).

Okanogan County

Need	Distribution of Trauma Verified Services
Okanogan FD #1 BLS Transport	 BLS Transport - Oroville Ambulance Service
Okanogan FD #2 BLS Transport	 BLS Transport - Coulee Dam Volunteer FD
Okanogan FD #3 BLS Aid BLS Transport ALS Transport	 BLS Aid - Not Currently Provided (#1) BLS Transport - Okanogan Co. FD #5 ALS Transport - LifeLine Ambulance, Inc
Okanogan FD #4 BLS Aid BLS Transport	 BLS Aid - Not Currently Provided (#1) BLS Transport - LifeLine Ambulance Inc.
Okanogan FD #5 BLS Aid BLS Transport	 BLS Aid - Not Currently Provided (#1) BLS Transport - Okanogan Co. FD#5
Okanogan FD #6 BLS Aid ALS Transport	 BLS Aid - Twisp Fire & Rescue ALS Transport - Aero Methow Rescue Service
Okanogan FD #7 BLS Aid ALS Transport	 BLS Aid - Not Currently Provided ALS Transport - LifeLine Ambulance, Inc
Okanogan FD #8 BLS Aid BLS Transport ALS Transport	 BLS Aid - Not Currently Provided, (Malott FD Licensed Only) BLS Transport - Okanogan FD #5, ALS Transport - LifeLine Ambulance, Inc.
Okanogan FD #9 BLS Aid ALS Transport	 BLS Aid - Conconully Volunteer Fire Department ALS Transport - LifeLine Ambulance, Inc.
Okanogan FD #10 BLS Aid BLS Transport	 BLS Aid - Not Currently Provided (#1) BLS Transport - LifeLine Ambulance, Inc.
Okanogan FD #11 BLS Aid BLS Transport	 BLS Aid - Not Currently Provided (#1) BLS Transport - Oroville Ambulance Service, LifeLine Ambulance, Inc.
Okanogan FD #12 BLS Aid ALS Transport	 BLS Aid - Not Currently Provided (#1) ALS Transport - LifeLine Ambulance, Inc.
Colville Tribal Reservation BLS Transport	 BLS Transport - Colville Tribal Emergency Services, Bridgeport Ambulance, Coulee Dam Fire Dept., Okanogan FD #5

Okanogan County Unmet needs;
1. Within the boundaries of Okanogan County FD #3, #4, #5, #10, #11 & #12, there is a need for BLS aid due to the sometimes-lengthy response by the nearest ambulance.
2. Encourage Malott FD to provide verified BLS Aid in south end of Fire Dist. #3.

Using the attached Table B., For each county, specify in the appropriate columns

TABLE B

Min/Max Numbers for Verified Trauma Services*

NORTH CENTRAL REGION OKANOGAN COUNTY

6/30/2001

Services	No Change In Status	Number Currently Verified	Minimum Number		Maximum Number	
			Approved	Recommend	Approved	Recommend
AID						
BLS	**X**	**2**	**1**	**1**	**7**	**9**
ILS	**X**	**0**	**0**	**0**	**0**	**0**
ALS	**X**	**0**	**0**	**0**	**0**	**0**
AMBULANCE						
BLS		**4****	**3**	**3**	**6**	**6**
ILS	**X**	**1**	**0**	**0**	**2**	**2**
ALS	**X**	**1**	**1**	**1**	**2**	**2**

*** As identified in the approved regional response plan.**
**** Current Number of Verified BLS Transport has changed due to Okanogan FD #4 contracting with LifeLine Ambulance to provide service within their response area.**

2. **Strengths and Weaknesses:** Discuss the strengths and weaknesses of the existing regional prehospital service delivery system.

Strengths:

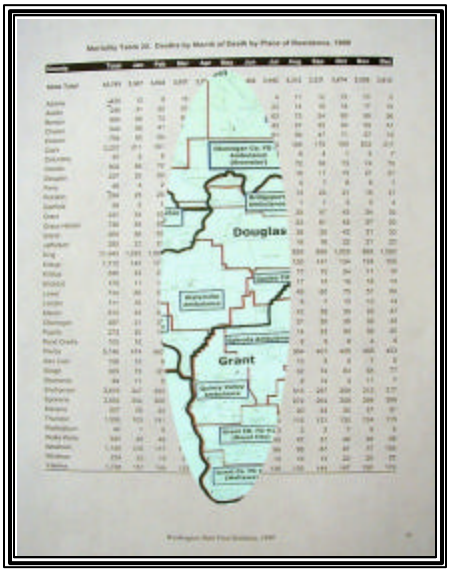
- The North Central Region is blessed with having dedicated volunteer personnel with many years of EMS experience
- The Multi-Agency Communications Center (MACC) in Grant County, is viewed by many as a strength. Though not without its problems, it provides a central communication site for all EMS, local law enforcement and fire departments and districts within Grant County.
- Within Chelan/South Douglas Counties, a recognized strength is the willingness of all agencies to collaborate in the delivery of EMS response.
- Okanogan/North Douglas' local council has been working diligently to develop a rapport between agencies that will be beneficial to all.
- All areas of North Central Region are currently receiving transport service.
- ALS coverage is available, either as primary transport or rendezvous, to the majority of the citizens of the region.
- The Multi Agency Communications Center in Grant County is an agency formed to provide centralized 911 services. It is the primary PSAP for Grant County and provides all emergent and most non-emergent dispatch in the county for Law, Fire and EMS. The simulcast radio system provides good coverage in the county. All counties in the region have 911 capabilities and to a large extent are centralized.
- The majority of licensed and verified agencies in the region have signed the Regional Mutual Aid Agreement and will back up other agencies within their counties and regionally.
- MedStar based in Moses Lake and Spokane, and Airlift Northwest based in Wenatchee, and Seattle provides air medical response within the region.

Weaknesses:

- Within the Wenatchee area, two ambulance services provide ALS services. Currently, they are dispatched on an every-other call basis. This system does not always ensure that the nearest available ambulance is dispatched to the incident. This dispatch situation may result in delayed response. Both the Local and Regional Councils are working to develop a system that will ensure the nearest and most appropriate ambulance is dispatched to the incident.
- Within the central part of Grant County, the area that encompasses the geo-political boundaries of Grant County FD #5, #4 and the Port of Moses Lake, it has been identified that an ALS service is necessary to provide response to a growing population base. The Grant County EMS & Trauma Care Council has recommended and the North Central Regional Council recommends an increase in ALS transport verification maximums for this area. The added ALS transport verification should serve Grant Co. FD #5 and #4 proper and is reflected in the proposed increase in maximum numbers of ALS verified transport agencies. The Regional Council has agreed with the Grant County Council and it further recommends that the existing service contracted to provide service within Grant County FD #5 & #4's geo-political boundaries advance to ALS status to provide service in the area. Recognizing that an

existing service is located near Grant County FD #5 boundaries, in the City of Moses Lake, the Local Council and the Regional Council will be working with the licensed and verified ALS agencies to ensure that the nearest available ambulance is dispatched to any incident.

- Throughout the region, there are long distances between EMS providers and incident locations. Though it is impossible to alleviate all long responses to these rural areas, the regional council will be looking for ways to shorten them where possible.
- The recruitment and retention of volunteers is an ongoing process. Due to low numbers of extensively trained volunteers many rural areas are experiencing extended daytime response time.
- Due to the proximity of trauma centers both inside and outside of the region, both the providers and their patients experience extended travel times. This is a patient care consideration as well as an obstacle to volunteer agencies.



3. **Demographics:** Identify specific demographics of the region that may drive the expansion of the existing prehospital service delivery system. Using the State of Washington 1999 Data Book, identify the following for each Prehospital Response Area when possible or at minimum for each county.

a. Land area-

Chelan County: 2,921.6 sq. miles; Douglas County: 1,820.6 sq miles;

Grant County: 2,676.4 sq miles; Okanogan County: 5,268.3. sq miles

Ranking of land area in the state-

Chelan County: 3, Douglas: 17; Grant County: 4; Okanogan: 1.

b. Land area in incorporated areas-

Chelan County: 13.87 sq. miles; Douglas County: 4.94 sq. miles;
Grant: 27.99 sq. miles; Okanogan: 17.3 sq. miles

c. Land area in unincorporated areas -

Chelan county: 2907.73 sq. miles; Douglas County: 1815.66 sq. miles;
Grant County: 2648.41 sq. miles; Okanogan County: 5251.0 sq. miles

d. Total population-

Chelan County:	63,000;	Douglas County:	31,700;
Grant:	70,600;	Okanogan County:	38,400.

e. Population density-Density per square mile-

Chelan County:	21.6;	Douglas County:	17.4;
Grant County	26.4;	Okanogan County:	7.3

f. Proportion of population in incorporated areas-

Chelan County:	34,915;	Douglas County:	9,845;
Grant County:	35,411;	Okanogan County:	15,595.

g. Proportion of population in unincorporated areas-

Chelan County:	28,085;	Douglas County:	21,855;
Grant County:	35,189;	Okanogan County:	22,805.

If appropriate also review and discuss other data elements such as total numbers of licensed drivers/licensed vehicles in the region and miles of roads in the region.

Licensed drivers per county-

Chelan County:	48,747;	Douglas County:	21,596;
Grant County:	49,088;	Okanogan County:	30,337.

Licensed Vehicles per county-

Chelan County:	79,685;	Douglas County:	27,312;
Grant County:	74,588;	Okanogan County:	43,289.

4. **Goals**: Identify the Regional EMS/TC system's long term and short-term goals, objectives, strategies and projected costs to improve the overall verified Pre-Hospital EMS and Trauma Service response in the region.

Short Term Goals

In coordination with the local councils and MPDs, the Regional Council will work to ensure that in areas where two agencies of equal licensure and verification levels co-exist, the closest available responding unit will be dispatched.

The Region will investigate all response areas within the region to ensure that all agencies are cognizant of their response zones.

Long Term Goals

Determine which current BLS services should consider upgrading their /license/certification level to ILS, if ALS services cannot be supported.

Increase the number of volunteers within the region.

Objectives

Establish a committee or assign to an existing committee the task of identifying BLS agencies that should consider upgrading their certification/license levels to enhance service provided to the region.

Provide throughout the region, recruitment and retention courses for agencies in the region wanting to increase their volunteer numbers.

Strategies

Using response numbers as a guide, determine which BLS agencies should consider upgrading to ILS or even ALS if possible. Economics will be a barrier that may drive the decision.

At selected local council meetings throughout the region, provide retention and recruitment courses for agencies in need of volunteers.

Projected Costs

The cost to the region will be minimal, though the cost to the agencies involved in the possible upgrade may be significant. It is not easily determinable as what those costs may be.

The cost of providing those courses will be approximately $500.00. The region will coordinate the implementation of the courses.

E. Patient Care Procedures (PCPs) and County Operating Procedures (COPs):

1. **Current Status**: Describe the current status of regional PCPs and COPs:
   a. Currently, the North Central Region's PCP committee is meeting regularly to review and revise the existing PCPs and will, within the next six months, begin developing additional PCPs that are expressly designed to meet the needs of the North Central Region.
   b. Grant County has developed two COPs that are included in Appendix #2. Both the Greater Wenatchee EMS Council and the Okanogan/N. Douglas County EMS Council are just now re-evaluating their process of developing their own specific COPS.

2. **Strengths and Weaknesses:** Discuss the strengths and weaknesses of the current system to include an assessment of additional needs within the region.

Strengths

a. The cooperation and hard work of the local councils within the North Central Region has become a strength. The effectiveness of the PCPs, COPs and the plan in general is dependent upon the collaboration between the Regional Council, the Local Councils and the provider agencies. This collaboration is becoming more evident.
b. The dedication and hard work of the MPDs, in particular, Lance Jobe, MD, of the Greater Wenatchee EMS/TC Council has been helped elevate the region and the expectations of the EMS providers for direction from the Region and Local Councils.

Weaknesses

a. Within the Wenatchee area, due to two private ALS providers, the current system of dispatch is to rotate 911 calls between each service, depending upon where the ambulances are located, the nearest, most appropriate ambulance may not necessarily be dispatch to the incident. The Greater Wenatchee EMS/TC Council will be addressing this issue shortly in hopes of developing a more efficient response.
b. In various areas within the region, it is the desire of the MPDs to require shorter response times in areas that are currently considered rural, but can reasonably be expected to have response times more in line with what is required for suburban areas. These areas will be addressed by the Local Councils and forwarded to the Regional Council for discussion and recommendations.

3. **Demographics:** Identify specific demographics of the region that drive Patient Care Procedure development in the region.

a. In greater metropolitan areas, it is believed that requiring response times in line with the state defined urban response time criteria may be attainable and would better serve those areas.

4. **Goals:** list the Regional EMS/TC system's goals, objectives, strategies and projected costs to develop and/or improve the regional PCPs or county COPs.

Goals

a. Develop PCPs/COPs that would require that the agencies within specified areas

4. Develop PCPs/COPs that require the determination of the nearest ambulance within the Wenatchee area and require that that ambulance be dispatched to the incident.

Objectives

a. To lessen the response times within specified areas that can reasonably expect more rapid response.
b. More efficiently dispatch ALS response within the Wenatchee area.

Strategies

a. Have PCP committee propose PCP that will require more rapid responses within specific areas.
b. Have PCP committee propose PCP that will require that the nearest ambulance respond to any incident within the Greater Wenatchee area.

Costs

a. The raising of the response time standard may not have a cost associated to it as the affected providers agencies currently respond at the suburban standard within specific areas over 80% of the time.
b. Requiring the dispatching of the nearest known ambulance within the Wenatchee area will have a cost of approximately, $1200.00 per ambulance for GPS tracking equipment, and approximately $8000.00 for the communications center equipment to receive the GPS data.

F. Multi county or county/inter-regional Pre-Hospital Care: Discuss the development of inter-regional prehospital patient care procedures that address issues which cross regional and/or county boundaries if any, including the current status of any inter-regional patient care procedures, mutual aid or inter-local agreements for provision of care.

Within the North Central Region, nearly all EMS/TC agencies have signed a mutual aid agreement, developed by the Regional Council (Appendix #5). There are currently no inter-regional PCPs or inter-local agreements within the North Central Region.

V. DESIGNATED TRAUMA CARE SERVICES

1. **Current Status**:
   a. List the currently designated trauma services (general and pediatric) and trauma rehabilitation services in the region.

The North Central Region currently has the following hospitals designated:

Central Washington Hospital, Wenatchee:	Level II- Adult Level III- Peds
Lake Chelan Community Hospital, Chelan:	Level IV
Mid Valley Hospital, Omak:	Level IV

North Valley Hospital, Tonasket:	Level IV
Okanogan-Douglas County Hospital:	Level IV
Samaritan Healthcare, Moses Lake:	Level IV
Cascade Medical Center, Leavenworth:	Level V
Columbia Basin Hospital, Ephrata:	Level V
Coulee Community Hospital, Grand Coulee	Level V
Quincy Valley Hospital, Quincy:	Level V

b. Describe facility resources in regard to trauma specialty needs such as pediatric trauma, burn care, traumatic brain injury, spinal cord injury, multi-system injuries, surgical, imaging, critical care procedures, and trauma rehabilitation for pediatric, burn, TBI, spinal cord injury, and orthopedic injuries.

Central Washington Hospital- Level II – Adult, Level III Pediatric Trauma Center, Wenatchee Valley Medical Center - Level IIR - is the only rehab facility in North Central Region.

Resources outside of the region:

Sacred Heart Medical Center, Spokane	Level II A & P
Deaconess Medical Center, Spokane	Level II A & P
Harborview Medical Center, Seattle	Level I A & P

c. Discuss any unfilled need for trauma services (general and pediatric) and trauma rehabilitation services in the region, and regional plans to meet these needs.

Currently, there are no Level III facilities in the North or East areas of our region. If a facility wants to increase their designation, a level III would be a benefit to the region. Due to distances from a higher level of designated trauma services, Mid-Valley Hospital in Omak and Samaritan Hospital in Moses Lake are obvious choices for facilities that may step up their designation. At this time, the Regional Council has no specific plan to meet these needs. These items will be discussed at the local and regional levels at which time a plan will be developed.

d. Identify training needs for Trauma Service and Trauma Rehabilitation Service Personnel:

1.) Include a narrative description of the trauma care workforce resources in the region including needs for additional nurses, physicians, or other providers and planned solutions.

Workforce resources within the region are reflective of the healthcare field in general. Predictably, the more rural hospitals in our system have difficulty finding and retaining personnel. (None of the facilities has a special need for resources.) A solution to the personnel issue is not easy to find. The basic problem, of course, is fewer people entering the healthcare field now. This is complicated for rural hospitals by the financial picture. Because they offer fewer services, rural hospitals can't offer the same level of experience

individuals can get in larger hospitals. This makes it difficult for rural hospitals to compete for the declining resources. The lack of direct funding from the state for trauma training, inclusive of pediatric trauma training is a problem. Possible solutions to this issue is training via telemedicine and facility collaboration on classes. This trauma training will ensure basic level of certification for all nurses providing hands-on care.

2.) Describe training resources currently available for trauma service personnel.

ACLS, TNCC & PALS are held at Central Washington Hospital. In 2000, CWH sponsored the instructor to teach an advanced TNCC class- first time offered in the North Central Region. Due to CWH Pediatric Trauma level, all ER & ICU nurses are required to go through an 8hour course on Pediatric Trauma care. This class is trauma specific to pediatric age groups. CWH is site for on-going training for prehospital personnel for invasive procedures and advanced airway techniques. Wenatchee Valley College has an EMT-B program offered Fall & Winter Quarter of every year.

3.) Discuss remaining training needs for trauma care personnel to maintain existing level of personnel, and any planned increase in trauma care personnel within the region.

The foremost need recognized is readily available, regular continuing education region wide. For much of the region, trauma specific training to maintain designation is less available. It is costly putting on the specialized courses such as ACLS and PALS. Rural hospitals, with their limited staff, can't fill a class with enough people to make it worthwhile. They are forced to send their employees to outside courses. Hospitals in the North Central Region send their people all over the state to get and maintain the needed training. There are only a limited number of courses offered within the region. This makes it costly for smaller hospitals to maintain the training needed to keep their designation. Central Washington Hospital does have the Education Resource Center that helps coordinate ongoing ACLS, PALS and TNCC classes. Also, CWH has trauma and case reviews taking place for the ER staff. Ongoing state funded training for the Trauma Coordinators to evaluate trauma programs would benefit the regional hospitals.

2. **Demographics:**

a. Identify specific demographics of the region that are likely to require additional designated trauma services or trauma rehabilitation services including total population of region, seasonal changes, licensed drivers, licensed vehicles, miles of roads, road or traffic conditions, current or anticipated industry.

The total current population in the North Central Region is 203,700; this is made up from the incorporated population of 95,766 and the unincorporated population

of 107,394. The total land area for our region is 12,686.9 square miles. Okanogan County ranks first in the state for a square mile area of 5,268.3, while being ranked 34th in the state for only 7.3 density. This is very indicative of the North Central Region, thereby creating a difficulty in designating additional trauma service needs. For the Lake Chelan, Twisp, George, Banks Lake, Sun Lakes and Winthrop areas, summer tourism creates a much larger population base than other times of the year, thus not substantiating a true need for additional designation.

3. **Designated general, pediatric and rehabilitation trauma facilities:** Regional review of recommended minimum and maximum numbers of designated trauma facilities within the region.

From a survey of the healthcare facilities, these are the recommended min/max numbers that we would like to see in the region:

Specify the region's recommendations for minimum and maximum numbers and levels of designated trauma and trauma rehabilitation services using Table C. Justify changes from previous recommendations based on identified need and distribution

TABLE C

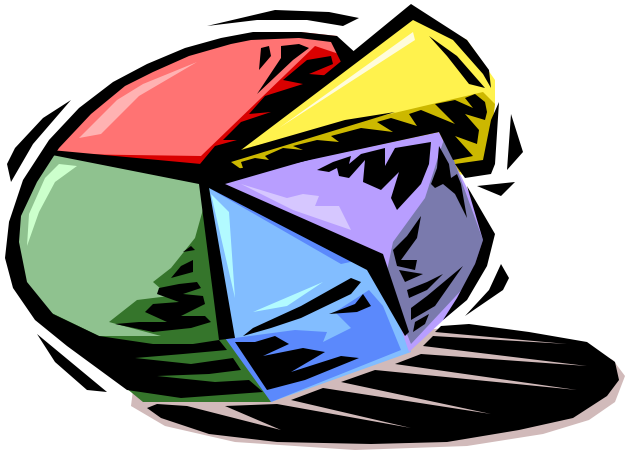
Min/Max Numbers for Acute Trauma Services

LEVEL	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
II	1	1	1	1	1
III	2	2	0	2	2
IV	4	4	5	4	4
V	3	3	4	3	3
IIP	1	1	0	1	1
III'	1	2	1	1	2

Min/Max Numbers for Rehabilitation Trauma Services

LEVEL	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with a *)	
	MIN	MAX		MIN	MAX
II	1	1	1	1	1
III+			0		

+ There are no restrictions on the number of Level III Rehab Services



VI. DATA COLLECTION AND SUBMISSION

A. Data:

1. Discuss the role the Regional EMS/TC system may have in the transition of prehospital to hospital submission of prehospital trauma data.

With the implementation of the Trauma Registry, the transition of prehospital trauma data to hospital allows for sharing of MIR information and tracking of pertinent run statistics. The trauma data that is submitted to our Regional office has aided in the sharing of trauma data. Also, due to the requirement of submitting MIRs, EMS agencies are more apt to submit completed trip sheets for the hospitals.

2. Assisting with improving the quality of prehospital trauma data collection through completion and submission of trauma patient run sheets to designated trauma services. (an example might be improving the method of getting dispatch times from communications centers.)

Developing a run sheet to address the particular information needs of EMS agencies, the regional trauma registry and hospital registry would enhance the submission of trauma information.

VII. EMS AND TRAUMA SYSTEM EVALUATION (Including both prehospital and hospital components):

A. Effectiveness and Quality Assurance

1. Describe the Regional EMS/TC system's role in the EMS and trauma system quality assurance including support of trauma registry data collection and submission. Include discussion of provider-specific QA activities within the region. Identify any issues that limit effectiveness of QA within the region.

Central Washington Hospital is the site of the bi-monthly Regional QI Committee meetings. This committee has been meeting regularly. Until the last two years, the committee devoted all of its time to designated facility data review. Since that time, the EMS providers of the region have taken a more active role in the committee and this is expected to continue. The areas of discussion range from on scene transports, and interfacility transports to appropriate trauma triage tool usage.

Numerous provider agencies conduct their own in-house QA activities. The region has not surveyed those agencies to gather data on those activities. The region will be more aggressive in the coming year in an effort to gather appropriate data and be more active in the QA process throughout the region.

APPENDIX #1

North Central Region EMS & Trauma Care Council

Patient Care Procedure
Dispatch of Agencies

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE

1. To provide timely & appropriate care to all emergency medical & trauma patients as identified in WAC 246-976-390.
2. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
3. To establish uniform & appropriate dispatch of response agencies.
4. To utilize Criteria Based EMD trained dispatchers to identify potential Major Trauma incidents & activate the Trauma System by dispatching the appropriate services.

II. STANDARDS:

1. Licensed aid and/or licensed ambulance services shall be dispatched by trained dispatchers to all emergency medical incidents.
2. Verified aid and/or verified ambulance services shall be dispatched by trained dispatchers to all known injury incidents, which meet Trauma Registry Inclusion Criteria.
3. All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.

III. PROCEDURE:

1. The nearest appropriate aid and/or ambulance service shall be dispatched per the above standards as identified in the North Central Regional EMS/Trauma Care response area maps, or as defined in local and/or county operating procedures.

IV. DEFINITION:

1. Per WAC 246-976-010, "response time" is defined as "the time from agency notification until the time the first EMS personnel arrive at the scene."
2. "Appropriate" is defined as "the verified or licensed service that normally responds within an identified service area."

V. QUALITY IMPROVEMENT

The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE

1. To define prehospital response times for emergency medical & trauma incidents to urban, suburban, rural and wilderness areas in the North Central Region.
2. To define urban, suburban, rural and wilderness response areas.
3. To provide trauma patients with appropriate & timely care.

II. STANDARDS:

1. All verified ambulance & aid services shall respond to emergency medical & trauma incidents in a timely manner in accordance with WAC 246-976-390.
2. All licensed ambulance & aid services shall respond to emergency medical incidents in a timely manner.

III. PROCEDURE:

1. The Regional Council, with input from prehospital providers and Local Councils, shall identify response areas & times as urban, suburban, rural and wilderness.
2. Verified/licensed ambulance & verified/licensed aid services shall collect & submit documentation to ensure the following response times are met or exceeded as established by PCP, COP or WAC 246-976-390 & 430.

Aid Vehicle		Ambulance	
Urban	8 minutes	Urban	10 minutes
Suburban	15 minutes	Suburban	20 minutes
Rural	45 minutes	Rural	45 minutes
Wilderness	ASAP	Wilderness	ASAP

3. Verified aid & ambulance services shall provide documentation on major trauma cases to show the above response times are met 80% of the time.
4. County Operating Procedures must meet or exceed the above standards.
5. Verified/licensed ambulance & verified/licensed aid are encouraged to set the "Golden Hour" as a goal for wilderness response times.

IV. DEFINITION:

1. An agency response area or portion thereof:

a. **Urban** - an incorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 & a population density over 2,000 per square mile.

b. **Suburban** – an incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of 1,000 to 2,000 per square mile.

c. **Rural** - an incorporated or unincorporated area with total populations less than 10,000 or with a population density of less than 1,000 per square mile.

d. **Wilderness** - any rural area not readily accessible by public or private road.

2. **Agency response time** is defined as the time from agency notification until the time the first EMS personnel arrive at the scene. (This is defined in WAC and constitutes "activation time" plus "enroute time.")

V. QUALITY IMPROVEMENT:

1. The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE

1. To ensure that emergency medical & trauma patients who live in an area that is serviced by two or more ambulance providers, which have the same level of licensure, receive the timeliest & highest level of care that is available.

II. STANDARDS:

1. If available, the highest-level "appropriately staffed" ambulance within a designated area shall be dispatched to emergency medical & trauma incidents.

III. PROCEDURE:

1. Except when "extraordinary circumstances" exist, the highest level "appropriately staffed" licensed ambulance shall respond to all emergency medical & trauma incidents.
2. When a licensed ambulance provider is unable to immediately respond an "appropriately staffed" ambulance to an emergency medical or trauma incident, and there exists another ambulance which is "appropriately staffed" and capable of responding to the incident in a timely manner, then the service that was originally dispatched shall transfer the call to the second ambulance for response.
3. This procedure shall only apply to emergency calls received through the county 911-dispatch center.

IV. DEFINITION:

1. **Extraordinary Circumstances** shall be defined as situations out of the usual when all available ambulances from local licensed ambulance providers are committed to calls for service.
2. **Appropriately Staffed** shall be defined as an ambulance which immediately initiates it's response to an emergency medical or trauma incident staffed with at least two crew members which are certified to a level that is commensurate with the standard of care that has been set in the local area. (i.e., Paramedic/EMT, ILS-EMT/EMT, EMT/EMT or EMT/1st Responder)
3. **Highest Level** shall be defined as the service within the response area that has the highest level of certified personnel available, at the time of the call.

V. QUALITY IMPROVEMENT:

1. The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE:

1. To define who may initiate the request for on-scene emergency air medical services, and under what circumstances non-medical personnel may request on-scene air medical services.
2. To institute a program of continuous evaluation to determine the best utilization of air medical services in our region.

II. STANDARDS:

1. Early activation of air ambulance services should be initiated as soon as the medical condition of the patient and scene location/conditions would favor, by at least 10 minutes, air transport of the major trauma or critical medical patient.

III. PROCEDURE:

1. Air ambulance services should be used when it will reduce total out of hospital time for a major trauma patient by 10 minutes or more.
2. Air ambulance services may be used for medical and non-major trauma patients under special circumstance and only with clearance by medical control.
3. Prehospital personnel en route to the scene should make the request to place an air ambulance service on standby, or initiate a request for an on-scene response.
4. The call must be initiated through the appropriate medical emergency dispatching agency.
5. The helicopter communications staff will always give an approximate launch time, flight time and advise when lifted to the dispatchers requesting services.
6. The responding helicopter will make radio contact with the receiving hospital at, or shortly after liftoff from the scene.
7. An air ambulance that has been launched or placed on standby can only be cancelled by the highest level of transporting prehospital personnel dispatched to the scene.

IV. DEFINITION:

1. **Standby:** Upon receiving the request, dispatch will notify the pilot and crew of the possible flight. The crew will respond to the aircraft and ensure they are in a flight ready status. The crew will then remain at or near the aircraft until such time as they are launched or released from the standby.
2. **Launch Time:** Launch time is the time the skids lift the helipad en route to the scene location.

V. QUALITY IMPROVEMENT:

1. A regional helicopter response report form for each flight or standby request, including cancelled flights, must be submitted to the QI Committee at the end of each calendar quarter. These will be reviewed, with local input, to develop a definition of the most appropriate circumstances for helicopter requests.

Adopted by Regional Council:	10/23/1998
Approved by DOH:	10/23/1998
Revised:	

I. PURPOSE

1. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedures.

2. To ensure that all emergency medical patients are transported to the closest most appropriate facility in the shortest time possible.

3. To ensure that all major trauma patients are transported to the most appropriate facility capable of meeting the patient's need in accordance with WAC 246-976-370.

4. To allow the designated facility sufficient time to activate their emergency medical and/or trauma resuscitation team. (See WAC 246-976-550 (d).

II. STANDARDS:

1. Major trauma patients will be identified in the initial EMS field assessment using the most current State of Washington Prehospital Trauma Triage (Destination) Procedures as published by the Department of Health.

2. Major trauma patients will be identified by the region's prehospital services and hospitals for the purposes of state trauma registry inclusion using the trauma registry inclusion criteria as outlined in
WAC 246-976-430.

3. Major trauma patients will be identified for the purposes of regional quality improvement as patients who meet the Trauma System Activation criteria of the most current version of the State of Washington Prehospital Triage Procedures, and patients who activate hospital resource teams and those who meet the hospital trauma patient registry criteria.

4. Patients not meeting the criteria to activate the trauma system will be transported to the closest most appropriate local facility as outlined in local procedures.

III. PROCEDURE:

1. The first certified EMS/TC provider to determine that a patient:
   a. Meets the trauma triage criteria and/or
   b. Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure)
   c. Needs definitive medical care should contact the nearest appropriate highest designated facility via the H.E.A.R. frequency (or other means as conditions dictate).

2. Radio contact with the receiving facility should be preceded with the phrase: "This is a major trauma or major heart alert."

3. The receiving facility shall be provided with the following information, as outlined in the Prehospital Destination Tool:

   a. Identification of EMS agency.
   b. Patient's age.
   c. Patient's chief complaint or problem.
   d. If injury, identification of the biomechanics and anatomy of the injury.
   e. Vital signs.
   f. Level of consciousness.
   g. Other factors that require consultation with medical control.
   h. Number of patients (if more than one).
   i. Amount of time it would take to transport the patient form scene to the nearest appropriate hospital (transport time).

4. When determined that a patient meets the trauma triage criteria, a Washington State Trauma Registry Band should be attached to the patient's wrist or ankle as soon as appropriate.

5. Whenever possible, ILS or ALS service should be dispatched to the scene by ground or air as appropriate. <u>If unavailable, rendezvous will be arranged with the highest possible level of care.</u>

6. While enroute to the receiving facility, the transporting agency shall provide complete report to the receiving hospital regarding the patient's status.

7. All information shall be documented on an appropriate medical incident report (MIR) form approved by the county medical program director.

IV. QUALITY IMPROVEMENT

The regional quality improvement program shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

Adopted by Regional Council:	10/23/1998
Approved by DOH:	10/23/1998
Revised:	

I. PURPOSE

1. To ensure that trauma patients receive treatment in facilities that have made a commitment to the provision of designated trauma service.

2. To define the referral resources for inter-facility transfers of patients requiring a higher level of care or transfer due to situational inability to provide care.

3. To recommend criteria for inter-facility transfer of major trauma patients from receiving facility to a higher level of care:

II. STANDARDS:

1. Written transfer agreements will be in place among all facilities in the region and tertiary care facilities commonly referred to which are out of the region.

2. All interfacility transfers shall be in compliance with current OBRA/COBRA regulations and consistent with RCW 70.170.060(02).

3. Level IV and V facilities will transfer the following adult and pediatric patients to level I or II facilities for post resuscitation care:

Central Nervous System Injury Dx
Head injury with any one of the following:
- Open, penetrating, or depressed skull fracture
- Severe coma (Glasgow Coma Score <10)
- Deterioration in Coma Score of 2 or more points
- Lateralizing signs

Unstable spine
Spinal cord injury (any level)
Chest Injury Dx
Suspected great vessel or cardiac injuries
Major chest wall injury
Patients who may require protracted ventilation
Pelvis Injury Dx
Pelvic ring disruption with shock requiring more than 5 units of blood transfusion
Evidence of continued hemorrhage
Compounded/open pelvic fracture or pelvic visceral injury
Multiple System Injury Dx
Severe facial injury with head injury
- Chest injury with head injury
- Abdominal or pelvic injury with head injury

Burns with head injury

Specialized Problems
Burns > 20% BSA or involving airway
Carbon monoxide poisoning
Barotrauma

Secondary Deterioration (Late Sequelae)
Patients requiring mechanical ventilation
Sepsis
Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal, or coagulation systems)

4. All pediatric patients less than 15 years who are triage under Step I or II of the Prehospital triage tool, or are unstable after ED resuscitation or emergent observation intervention at hospital with general designations should be considered for immediate transfer to a level I designated pediatric trauma center.

5. For inter-facility transfer of critical major trauma patients, air or ground ALS transport is the standard. Trauma verified services shall be used for all inter-facility transfers of major trauma patients.

6. Transport of patients out of region shall be consistent with these standards.

III. PROCEDURE:

1. The General and Pediatric Trauma Transfer Criteria established by the Department of Health should be followed. Each designated trauma facility is required to develop procedures, protocols, and criteria defining which patients they keep or transfer.

2. The transferring facility must make arrangements for the appropriate level of care during transport.

3. The receiving facility must accept the transfer prior to the patient leaving the sending facility.

4. The receiving physician must accept the transfer prior to the patient leaving the sending facility.

5. All appropriate documentation must accompany the patient to the receiving facility.

6. The transferring physician's order shall be followed during transport as allowed by MPD protocols. Should the patient's condition change during transport, the transferring/sending physician, if readily available, should be contacted for further orders.

7. The receiving facility will be given the following information:

    a. Brief history
    b. Pertinent physical findings
    c. Summary of treatment
    d. Response to therapy and current condition

8. Further orders to transport personnel may be given by the receiving physician.

9. MPD approved Prehospital Protocols will be followed during transport, unless direct medical orders are given to the contrary.

10. Level IV and V trauma facilities should consider having trauma patients transferred by either ground or air according to the facility's interfacility transport plan.

11. Air transport should be considered for interfacility transfer in the North Central Region when transport by ground will be greater than 30 minutes.

IV. QUALITY IMPROVEMENT

The regional quality improvement program shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

Adopted by Regional Council:	10/23/1998
Approved by DOH:	10/23/1998
Revised:	

I. PURPOSE

1. To define implications for initiation of trauma center diversion (bypass) status in the Region.
2. To define the methods for notification of initiation of trauma center diversion.
3. To identify situations when a facility must consider diverting major trauma patients to another designated trauma center.

II. STANDARDS:

1. Designated trauma centers in the North Central Region will go on diversion for receiving major trauma patients based on the facilities' ability to provide initial resuscitation, diagnostic procedures, and operative intervention at the designated level of care.

2. Diversion will be categorized as partial or total based on the inability of the facility to manage specific types of major trauma or all major traumas at the time.

   Hospitals must consider diversion when:
   - Surgeon is unavailable
   - OR is unavailable
   - CT is down if Level II
   - ER unable to manage more major trauma
   - Beds are unavailable
   - Shortage of needed staff

3. Each designated trauma center will have a hospital approved policy to divert patient to other designated facilities on the ability to manage each patient at a particular time. A diversion log will be kept indicating the time of diversion and the reason for partial or total diversion.

4. All facilities initiating diversion must provide notification to other designated trauma centers in Region.

III. PROCEDURE:

1. Trauma centers will consider diverting major trauma patients based on the above standards.

2. A designated trauma center on partial or total diversion shall notify other designated trauma centers in the Region.

IV. QUALITY IMPROVEMENT

The regional quality improvement program shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

Appendix #2

Grant County EMS &
Trauma Care Council

County Operating Procedures
Procedure #1-Tiered Response Rendezvous

Adopted by Grant County Council:
Recommended by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

Purpose:

The Grant County Local Council encourages tiered response within the county. A tiered response system shall be used to provide an appropriate higher level of care anywhere in Grant County such care is readily available. Recognizing that there are areas where a tiered response is not appropriate because of time and distance, a rendezvous with an appropriate higher level of care will be requested, per Grant County EMS Protocols, anywhere in Grant County such a rendezvous is readily available.

Procedure for Tiered Response:

1. The nearest appropriately trained personnel and/or agency shall be dispatched as the primary ambulance.
2. If the severity of the incident is known and indicates the necessity of higher level of care, the dispatchers should also dispatch the next level of care immediately in those areas where the Grant County Local Council has identified a tiered response.
3. If the severity of the incident is unknown, the primary ambulance shall advise dispatchers to dispatch the next level of care as outlined in the Grant County Protocols. The primary ambulance will not delay transport to wait for the higher level of care, but will rendezvous instead.
4. When both agencies are on scene, the higher level personnel will assume care of the patient, and determine which ambulance transports.

Procedure for Rendezvous:

1. In areas where no tiered response has been identified, agencies should request a rendezvous with a higher level of care as outlined in the Grant County Protocols, if such care is readily available.
2. No agency, including ILS and ALS agencies, should delay transport of any patient to perform advanced skills that can be performed en route to the hospital.
3. When two agencies rendezvous, the higher level of care shall board the primary ambulance and assume responsibility for the care of the patient.

Quality Assurance:

The Grant County Quality Assurance Committee will analyze and make necessary changes in this procedure as may be indicated.

Adopted by Greater Wenatchee Council: May 15, 1996
Recommended by Regional Council: 1996
Approved by DOH: 1996
Revised:

Purpose:

1. To define the situations in which Advanced Life Support (ALS) agencies will be dispatched to emergency medical and major trauma incidents on U.S. 97 in Douglas County in the area between Sun Cove Estates and Twin W Orchards (milepost 224 to milepost 27).
2. To provide timely and appropriate care to all emergency medical and trauma patients.
3. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
4. To establish uniformity and appropriate dispatch of ALS response agencies.

Standard:

1. An ALS agency from Chelan shall be automatically dispatched to all known emergency medical and major trauma incidents on the above-mentioned stretch of U.S. 97 in Douglas County.
2. All major trauma patients on this stretch of U.S. 97 shall be automatically transported to highest-level designated trauma center.
3. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate.

Procedure:

1. Waterville Ambulance shall be dispatched to all major trauma incidents on U. S. 97 to milepost 227. If ALS (paramedic) certified personnel are part of the response team, the dispatch center shall be so notified.
2. When the location of the emergency medical or major trauma incident is south of milepost 224 (entrance to Sun Cove Estates), an ALS agency out of Wenatchee shall be automatically dispatched to the scene.
3. When the location of the emergency medical or major trauma incident is north of milepost 224, the ALS agency out of Chelan shall be automatically dispatched to the scene.
4. All major trauma patients shall be transported to Central Washington Hospital in Wenatchee if within 30 minutes transport time. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.
5. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate. If the patient has a life threatening condition, the patient should be taken to the closest appropriate facility per regional patient care procedures.

Quality Improvement:

The Regional Quality Improvement Committee shall develop written plan for implementation to address issues of compliance with the above standards and procedures.

Adopted by Greater Wenatchee County Council: May 15, 1996
Recommended by Regional Council: 1996
Approved by DOH: 1996
Revised:

Purpose:

1. To define the situations in which Advanced Life Support (ALS) agencies will be dispatched to emergency medical and major trauma incidents in the Douglas County Fire District #4 service area currently served by Waterville Ambulance (milepost 138 to milepost 142.5 on U.S. 2, and milepost 213 north to milepost 224 on U.S. 97.
2. To provide timely and appropriate care to all emergency medicaland trauma patients
3. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
4. To establish uniformity and appropriate dispatch of ALS response agencies.

Standard:

1. An ALS agency from Wenatchee shall be automatically dispatched to all known emergency medical and major trauma incidents on the above-mentioned areas in Douglas County.
2. All major trauma patients on the above-mentioned areas of Douglas County shall be automatically transported to highest-level designated trauma center.
3. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate.

Procedure:

1. Waterville Ambulance shall be dispatched to all major trauma incidents in the above-mentioned area. If ALS (paramedic) certified personnel are part of the response team, the dispatch center shall be so notified.
2. An ALS agency out of Wenatchee shall automatically be dispatched to all emergency medical and major trauma incidents in the above-mentioned area.
3. All major trauma patients shall be transported to Central Washington Hospital in Wenatchee if within 30 minutes transport time. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.
4. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate. If the patient has a life threatening condition, the patient should be taken to the closest appropriate facility per regional patient care procedures.

Quality Improvement:

The Regional Quality Improvement Committee shall develop written plan for implementationto address issues of compliance with the above standards and procedures.

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Appendix #3

COMMUNICATIONS COMMITTEE

1. The Communications Committee shall work towards the enhancement of communication for emergency medical services within the four counties of the North Central Region. This committee shall work with the Department of Health on any communication project which may become available within the North Central Region, and will help to coordinate communications intra/inter county-wide
2. The Committee shall be responsible for any other duties assigned by the Regional Council.

HEALTHCARE FACILITIES COMMITTEE

A. The HealthCare Facilities Committee shall coordinate with regional healthcare facilities to achieve the goal of providing the highest quality of care to trauma patients.

B. The Committee will work toward the development of strategies to obtain commitment to the availability of personnel, equipment and provider education.

C. The Committee will provide input to the Regional Council on minimum/maximum recommendations for trauma-designated facilities within the North Central Region.

D. The Committee will be responsible for any other duties as assigned by the Regional Council.

INJURY PREVENTION & PUBLIC EDUCATION COMMITTEE

A. The Injury Prevention & Public Education Committee shall develop prevention programs, based on regional needs, which will assist in preventing and reducing deaths and disabling injuries.

c. The Committee working with other healthcare professionals and community organizations will implement coordinated programs to benefit the greatest number of individuals possible.

d. The Committee shall be responsible for any other duties assigned by the Regional Council.

TRAINING AND EDUCATION COMMITTEE

A. The Training and Education Committee shall have authority, subject to the advance approval of the Executive and Finance Committees, to recommend a contract on behalf of the Regional Council for expenditure of training and education funds within the North Central Region, to serve the purposes of the Council as set forth in the Bylaws. The Training and Education Committee shall work with the Finance Committee in connections with expenditures of funds.

B. The Training and Education Committee may provide management and coordination of training within the North Central Region. This will include Basic Life Support (BLS), Intermediate Life Support (ILS), and Advanced Life Support (ALS) courses. The Committee will assess the

training requirements and coordinate with the local training agencies, to develop and publish the annual training schedule.

C. The Committee will develop the budget based on training requirements and work towards a reasonable and equitable distribution of funds throughout the region. The Committee will coordinate with other agencies, within the region, that are involved in other phases of training, certification, and re-certification.

D. The Training and Education Committee shall review disbursement of all funds to be utilized in any and all aspects of training and education requirements.

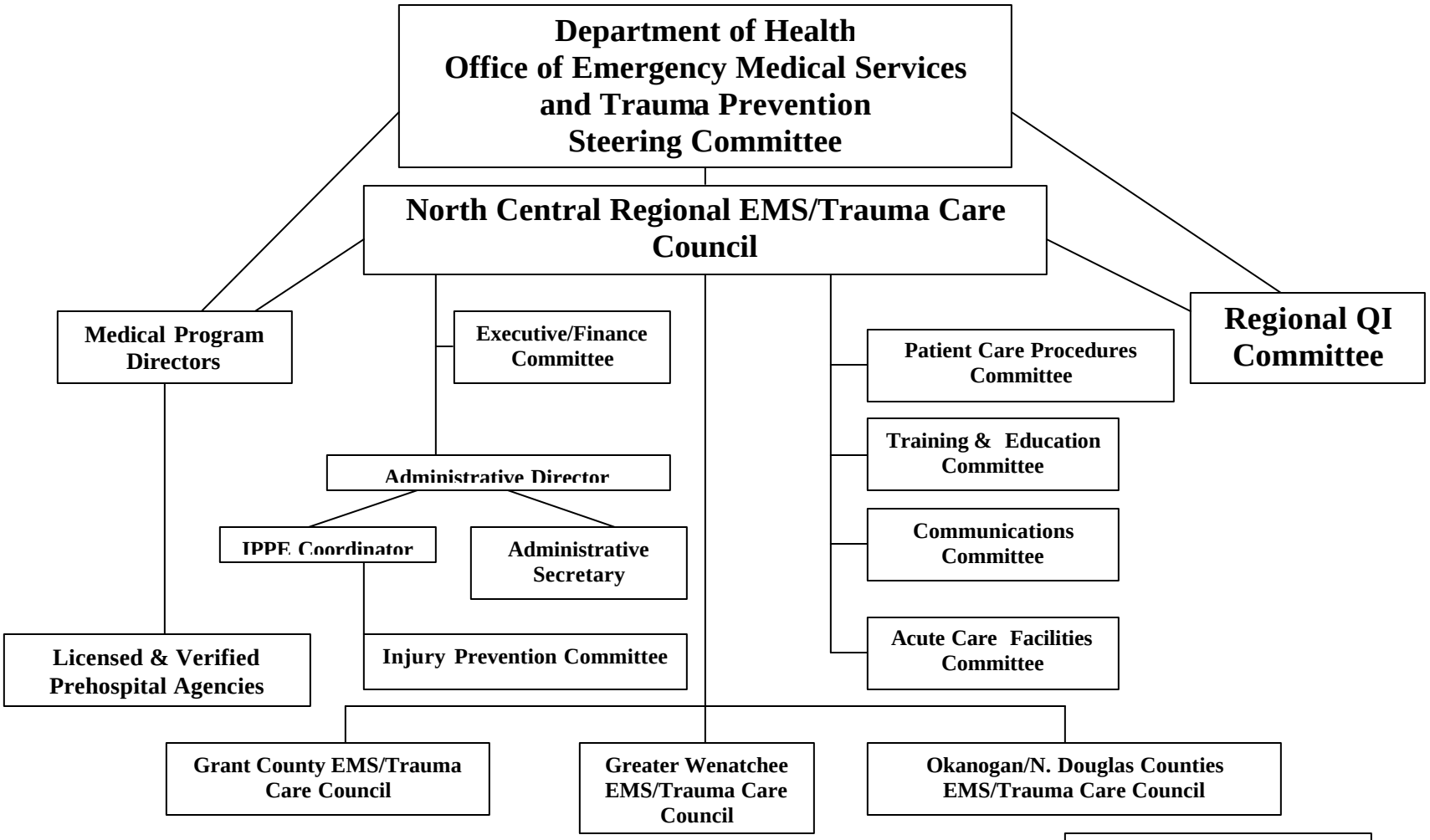
E. The Training and Education Committee shall also be responsible for any other duties as assigned by the Regional Council.

PATIENT CARE PROCEDURES COMMITTEE

A. Review, revise and develop Patient Care Procedures as needed.

B. Review and make recommendations for the revisions or development of County Operating Procedures.

NORTH CENTRAL REGION ORGANIZATIONAL CHART



Appendix #4

Appendix #5

North Central Region

Major Incident
Mutual Assistance Agreement

This agreement is made and entered into, by and between the undersigned emergency medical service (EMS) agencies of Chelan, Douglas, Grant and Okanogan Counties.

WITNESSETH:

Pursuant to the development of the EMS and Trauma Care delivery system in the North Central region vested in the Regional Council by the authority of the provisions of RCW 70.168, the undersigned parties mutually agree as follows:

WHEREAS, each of the parties hereto maintains equipment and personnel for the purpose of responding to medical emergencies within it's own service area; and

WHEREAS, each of the parties hereto desires to supplement the available local area mutual aid resources of medical emergency, rescue, and other emergency response capability available in it's respective service area in the event of a disaster level emergency situation; and

WHEREAS, it is deemed mutually sound, desirable, practicable and beneficial for the parties to this agreement to render assistance to one another in accordance with these terms;

NOW THEREFORE, in consideration of these mutual covenants of the parties hereto, be it agreed that;

SECTION 1. This agreement shall be deemed effective when each party has approved this agreement and has filed a signed copy of this with the North Central Regional EMS and Trauma Care Council office.

SECTION 2. Whenever it is deemed advisable and appropriate by the officer in charge of the EMS agency of any party hereto by reason of a disaster level emergency medical or other emergency situation within such party's service area, he/she is authorized to request assistance under terms of this agreement from the appropriate participation party or parties.

SECTION 3. The officer in charge of the EMS agency requesting assistance (unless this authority has been delegated) shall assume full charge of the operations; however, personnel and equipment of the party rendering assistance shall remain under the immediate supervision of and shall be the immediate responsibility of the officer in charge of said party rendering assistance.

SECTION 4. The party rendering assistance shall be responsible for the delivery of requested equipment and manpower as requested, provided:

A. The party rendering assistance under terms of this agreement shall not be required to make resources available or render services to any other party when by doing so, an unreasonable danger to lives and property of that party's service area would result.

B. The party rendering assistance shall determine what resources and services can be reasonably provided within such limitation.
C. Each party should insure that one ground ambulance; with adequate manning, be available for service within it's respective service area at all times, either with it's own resources or standby assistance, to provide a measure of protection to that area.

SECTION 5. The party requesting assistance under this agreement assumes no responsibility for the payment of services. It shall be responsible for providing, at the scene, operating supplies for the equipment and welfare items for personnel, as necessary.

SECTION 6. Each party hereto assumes responsibility for and liability for normal maintenance, repair, damage, personal injury or death arising out of the performance of this agreement. In the event there is any loss, damage, personal injury or death, or property damage arising out of the performance of this agreement caused by any party's negligence, then said party shall be responsible for such damage or injury and does hereby agree to indemnify and hold harmless any other party as to any such damage or injury, including all costs expenses and fees. Each party agrees to maintain adequate insurance, not less than one million dollars, on its perspective operation, equipment and personnel.

SECTION 7. Each party to this agreement will establish a system within it's respective county, to mobilize requested resources, and each county will establish a single point emergency contact for resource requests

SECTION 8. This mutual assistance agreement is in addition to existing local mutual aid agreements, and shall not supersede such agreements.

SECTION 9. This agreement shall take effect upon signature and filing in the North Central Regional EMS and Trauma Care Council and shall remain in force and effect until canceled by mutual agreement of all the parties hereto or by written notice by one party to all other parties giving thirty days notice in writing of such cancellation. Each party shall review this agreement every three years, with the next review to be completed by December 31, 2003

I understand that this agreement is currently in effect for my agency, my signature below affirms my review of this document.

_____ _____

Agency Representative Signature **Date**

_____ _____

North Central Region Representative **Date**

Appendix #6

Agencies with Signed Mutual Aid Agreements FY02:

Chelan/So. Douglas County (Greater Wenatchee EMS Council):

Ballard Ambulance Service
Cascade Ambulance Service
Chelan County FD #1
Chelan County FD #3
Chelan County FD #4
City of Wenatchee Fire & Rescue
LifeLine Ambulance, Inc.-Wenatchee
Chelan County PHD #2- Lake Chelan Community Hospital EMS
Peshastin Fire Dept
Waterville Ambulance

Affiliated Service:
Mission Ridge

Grant County (Grant County EMS Council):

Coulee City Fire Dept
Ephrata Ambulance Service
Grand Coulee Volunteer Fire Dept & Ambulance
Grant County FD #3
Grant County FD #5
Grant County FD #6
Grant County FD #7
Grant County FD #8
Grand County FD #10
Moses Lake Fire Dept
Soap Lake Ambulance

Okanogan/No. Douglas County (Okanogan/No. Douglas EMS Council):

Aero Methow Rescue
Colville Tribal Emergency Services
Conconully Fire Dept
Coulee Dam Fire Dept
LifeLine Ambulance, Inc.-Omak
Mansfield Volunteer Fire Dept
Okanogan County FD #5
Oroville Ambulance Service

Appendix #7

Summary of Steering Committee and Department of Health recommendations for FY 00 – 01 Plan

Injury Prevention and Public Education

2002 – 03 Plan is more specific regarding strategies and plans, see pages 17 & 18.

Human Resources

Hospital resources addressed in Designated Facilities section on page 47.

Prehospital

More detailed section included in this plan.
Communications more detailed
Patient Care Procedure "Response Times" addresses expectations
Min/Max numbers have been reviewed and revised as needed , see "Table B pages 38 – 41 and page 42 for explanation.

Definitive Care

Current facilities are reflected accurately
Min/Max numbers have been reviewed and revised as needed, see "Table C page 48."

Appendix #8

North Central Regional Plan Questionnaire

Agency Name _____

(Use back of these pages as necessary)

1. Is your EMS agency governed by any "new" local ordinances? Yes / No
   If yes – Describe the potential effects of these ordinances.

2. What local system improvements, projects and their costs, and possible resources would you like implemented?

3. Does your EMS agency use online and/or offline medical direction? What are the strengths and weaknesses of the current system?

4. Is your EMS agency licensed only or licensed & verified?

5. How many response vehicles do you operate? Of what type? (i.e. aid or ambulance)

6. List the total number of personnel and their certification levels.

7. Do you anticipate increasing/decreasing or changing any of numbers 5 & 6.
   Yes / No
   If yes – describe possible changes.

8. Does the current training program, provided by the Inland Empire Training Council thru contract with the North Central Region, meet your needs? Yes / No
   If no – suggest ways of improving the training program.

9. What public safety personnel (fire departments, law enforcement, military, etc.) may be available to your service if needed and what role would they fill?

10. Is there any particular demographics in your service area that may influence the need for expanded personnel and training?

11. Provide a written description of your response area boundaries. (i.e., Hwy 97A and Navarre-Coulee Rd. (SW), top of McNeil Canyon (NW), etc.)

12. Describe both strengths and weaknesses of your current EMS response system.

13. Do you regularly provide patient care across county and/or regional boundaries? Yes / No
    If yes – do you have inter-local agreements and do they address patient care procedures?

14. Does your agency have a Quality Assurance process? Yes / No
    If yes – Describe its operation and effectiveness.

_____	_____
Agency Representative	Phone #
_____	_____
Email Address	Fax #